MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12169 12164

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 913 Ridgewood St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 913 Ridgewood St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PANTELIS Middle Last ACHILLIOS
4. DATE OF DEATH: Month 9 Day 30 Year 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 14, 1904
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State, or foreign country): Cyprus
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 220-03-1564
17. INFORMANT: Nick Pantelides Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive cerebro-vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus; cirrhosis of liver (Laennec's)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June, 19 15, to Sept, 19 66, that (I) (we) last saw the deceased alive on Sept 28 1966, and that death occurred at 7:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: John M. Layla M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/1/66
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-3-1966
23c. NAME OF CEMETERY OR CREMATORY: St. Demetrius
23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: John M. Layla & Sons ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: OCT 6 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12170 12165

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 25 Clay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): #33154 — First: Roland — Middle: — Last: Adams

4. DATE OF DEATH: Month: 9 — Day: 29 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/14/1919

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd Jobs

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Adams

14. MOTHER'S MAIDEN NAME: Nannie Jane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes

16. SOCIAL SECURITY NO.: 219-46-1603

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO
(b): Severe Pulmonary
DUE TO
(c): Bronchogenic Carcinoma with Generalized Metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. ---------- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/30/ , 1966 , to 9/29/ , 19 66 that (I) (we) last saw the deceased alive on 9/29/ 19 66, and that death occurred at 4:40 P.M. from causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/30/66

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-4-1966

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: [illegible]

25a. REC'D BY REGISTRAR — DATE: OCT 3 1966

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12171

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12166

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: Hrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perfy Hall
   d. STREET ADDRESS: 4124 Loch Lomond Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: A. — Last: AGRO

4. DATE OF DEATH: Month: September — Day: 6, — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3- 1929

9. AGE (In years last birthday): 37 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rigger

10b. KIND OF BUSINESS OR INDUSTRY: Baltimore Rigging

11. BIRTHPLACE (State or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Agro

14. MOTHER'S MAIDEN NAME: Grace M.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): Korea

16. SOCIAL SECURITY NO.: 219-22-2535

17. INFORMANT: Mrs Ruth Agro 4124 Loch Lomond Drive — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Multiple severe injuries — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b)
   DUE TO
   (c)

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Working on roof and it gave way and fell 125 ft.

20c. TIME OF INJURY Month, Day, Year: Hour 2:00 p.m. 9-6 1966

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Factory

20f. (City or town) (County) (State): Glen Burnie A.A. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: September 7, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-10-1966

23c. NAME OF CEMETERY OR CREMATORY: Dulaney Valley Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore Co. Md.

24. FUNERAL DIRECTOR — ADDRESS: Lassahn Funeral Home 2401 Belair Road (36)

25a. REC'D BY REGISTRAR DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12172 12167

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 14 years

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Crownsville State Hospital
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Estelle Middle L Last Barton

4. DATE OF DEATH: Month Sept Day 25th Year 1966

5. SEX: Fe
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/9/93
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart Failure
4201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocardial Infarction.
DUE TO (c): Arteriosclerosis.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 22nd Sept, 1952, to 25th Sept, 1966, that (I) (we) last saw the deceased alive on 25th Sept 1966, and that death occurred at 11:45 M, from the causes and on the date stated above.

22a. SIGNATURE: Alvin Thompson M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 9/25/66.
22c. PHYSICIAN'S NAME (Type): Alvin Thompson
22d. ADDRESS: Crownsville State Hosp.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 9.30-66
23c. NAME OF CEMETERY OR CREMATORY: U. Md. Med. School
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: W Rose #
ADDRESS: 10 W WASH ST
25a. REC'D BY REGISTRAR DATE: OCT 5 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12175

CERTIFICATE OF DEATH

12168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ANNE ARUNDEL — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS c. LENGTH OF STAY IN 1b: 8 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNAPOLIS NURSING HOME	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: A.A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HARWOOD d. STREET ADDRESS: WESTON e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: ~~BATES~~	Middle: ELIZABETH	Last: Bates	4. DATE OF DEATH	Month: SEPT	Day: 23	Year: 1966	
5. SEX: F	6. COLOR OR RACE: CAU	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: OCT 31, 1889	9. AGE (In years last birthday): 76 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): JOHNSTOWN, PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN GOLLAR		14. MOTHER'S MAIDEN NAME: Katherine Byers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: NONE	17. INFORMANT: MRS. E.R. MEYER, DAU, SAME AD. (Address)	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	SHOCK	12 HOURS
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	ENDOTOXINS, GRAM-NEGATIVE ORGANISMS	4 DAYS
DUE TO (c)	SEPTICEMIA	4 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): OBLITERATIVE CHOLANGITIS, MULTIPLE DECUBITUS ULCERS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9 JAN, 1966, to 23 SEP 1966 that (I) (we) last saw the deceased alive on 21 SEP 1966, and that death occurred at 5:00 A M, from causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 23 SEP 1966

22c. PHYSICIAN'S NAME (Type): CHARLES W. KINZER — 22d. ADDRESS: SOUTH RIVER MED CENT. EDGEWATER, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
Removal-Burial	Sept. 26, 1966	Grandview Cemetery	Johnstown	Cambria Pa.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Hopping Funeral Home, Annapolis, Md. — Beverley E. Hopping

25a. REC'D BY REGISTRAR DATE: SEP 27 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12174 — 12169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and (if any) within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elvaton
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital	d. STREET ADDRESS: Millersville P. O. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First: Marion — Middle: Lenore — Last: BLOOM	4. DATE OF DEATH Month: September — Day: 24 — Year: 19 66
5 SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: June 26, 1926 — 9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b KIND OF BUSINESS OR INDUSTRY: Own Home — 11 BIRTHPLACE (County & State, or foreign country): Severn, Md. — 12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: Allen Stevenson — 14. MOTHER'S MAIDEN NAME: Lenora Durner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service) — 16. SOCIAL SECURITY NO.: 216-20-2621 — 17. INFORMANT. Address: John P. Bloom, same as 2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): metastatic Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: I / I X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Sept 22, 1966, to Sept 24, 1966, that (I) (we) last saw the deceased alive on Sept 24 19 66, and that death occurred at 6:40 P.M., from causes and on the date stated above.

22a. SIGNATURE: Ray M. Smith — M D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Sept 25, 1966

22c. PHYSICIAN'S NAME (Type): RAY M. SMITH — 22d. ADDRESS: Severna Park Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	28 Sept. 66	Glen Haven Memorial	Glen Burnie, Md.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 29 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. No. 12171

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDELL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 615 Second Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ANN ARUNDELL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 615 Second Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Reba — Middle: Pinkney — Last: Booth

4. DATE OF DEATH: Month: 9 — Day: 27 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept 6 1902

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: London Pinkney

14. MOTHER'S MAIDEN NAME: Elizabeth Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: NONE

17. INFORMANT — Address: Mary Ellen Henderson ANNAPOLIS, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Day
171 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1964, 19____, to 1966, 1966, that I last saw the deceased alive on 9/27/66, 19____, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): [signature] — DATE SIGNED

PHYSICIAN'S NAME (Type): E. Linhardt — Annapolis - Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BP

22b. DATE THEREOF: 10/1/66

22c. NAME OF CEMETERY OR CREMATORY: Annapolis Neck

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John B. Johnson Jr. — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 3 1966 — OCT

24b. REGISTRAR'S SIGNATURE: Charles Jaggers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12176 — 12171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Ross Cove and Holly Pt. Dr. (Lake Shore)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Leonard — Last: Boushell Sr.
4. DATE OF DEATH: Month: Sept. — Day: 4 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 7, 1903
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edgar Boushell
14. MOTHER'S MAIDEN NAME: Irene (unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 219-32-0749
17. INFORMANT: Mrs. Rose A. Boushell (Wife) — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Generalized Carcinoma of Bowel — INTERVAL BETWEEN ONSET AND DEATH: (1½ months)
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1007
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to 9/4, 19 66, that (I (we) last saw the deceased alive on Sept 4 19 66, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: E. W. Chaney M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: September 4, 1966
22c. PHYSICIAN'S NAME (Type): Paul V. Chaney, MD
22d. ADDRESS: 801 Crain Hwy So Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 7, 1966
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park
23d. LOCATION (City, town or county) (State): Glen Burnie, Md.
24. FUNERAL DIRECTOR: R. V. Singleton — ADDRESS: Singleton Funeral Home Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: SEP 7 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12177 — 12172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE, MD
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): KIMBROUGH ARMY HOSPITAL, FGGMMD

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: OREGON — b. COUNTY: MULTNOMAH
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PORTLAND
d. STREET ADDRESS: 16820 S.E. ADLER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle JAMES — Last BRANDLOF

4. DATE OF DEATH: Month SEPT — Day 10 — Year 19 66

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 FEB 49

9. AGE (In years last birthday): 17 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): COOK, ILLINOIS/ILLINOIS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES N. BRANDLOF

14. MOTHER'S MAIDEN NAME: SHIRLEY J. WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES

16. SOCIAL SECURITY NO. (If yes give war or dates of service): 18 Mar 66-10 Sept 66/328--38--9072

17. INFORMANT: JAMES N. BRANDLOF — Address: 16820 S.E. Adler Portland, Ore.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): POSSIBLE HEAD INJURY AND INTERNAL INJURY — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
DUE TO (b): AUTO ACCIDENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): AUTO ACCIDENT

20c. TIME OF INJURY Month, Day, Year: Hour 2230 p.m. Sept 10 19 66

20d. INJURY OCCURRED White at work ☐ Not White at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): FGGMMD

20f. (City or town) (County) (State): FT GEO G MEADE, MD

21. I certify that (I) (this hospital) attended the deceased from [illegible] PT. WAS DOA, [illegible] that (I) (we) last saw the deceased on 10 SEPT 19 66, and that death occurred at 2230 PM, from causes and on the date stated above.

22a. SIGNATURE: Lynn W. Holder — M.O. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10 SEPT 66

22c. PHYSICIAN'S NAME (Type): LYNN W. HOLDER, CAPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSPITAL, FGGMMD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Sept.15,1966

23c. NAME OF CEMETERY OR CREMATORY: WILLAMETTE Nat. cemetery

23d. LOCATION (City or Town) (County) (State): Portland 66, Ore.

24. FUNERAL DIRECTOR — ADDRESS: Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 19 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12178 12173

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ---
c. LENGTH OF STAY IN 1b: NA

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: RFD #2 Box 176
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA USNH Annapolis, Md.

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ruth	E.	Brennan	Sept.	13	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Cauc.		11-17-03	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (County & State, or foreign country): Kings County, Brooklyn, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Rutherford
14. MOTHER'S MAIDEN NAME: Maria Maxwell City

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 219 30 4696
17. INFORMANT: (H) John B. Brennan — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries, Extreme
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile accident
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----
20f. (City or town) (County) (State): Rt. 460 West River, Annapolis

21. I certify that (I) (this hospital) attended the deceased from --- 19--- to --- 19---, that (I) (we) last saw the deceased alive on DOA 19---, and that death occurred at 10 AM, 13 SEPT 66, from the causes and on the date stated above.

22a. SIGNATURE: William Ross Kennedy MD — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 13 Sept. 66
22c. PHYSICIAN'S NAME (Type): WILLIAM ROSS KENNEDY, MD.
22d. ADDRESS: USNH, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-14 66
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven
23d. LOCATION (City, town or county) (State): Glen Burnie Md

24. FUNERAL DIRECTOR ADDRESS: Thomas A. Hardesty 12 Ridgely Ave, Annapolis, Md
25a. REC'D BY REGISTRAR DATE: SEP 21 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

Cleared with AA Co. Coriner
Dr. Elmer G. Linhardt

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12179 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12174

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) [illegible] General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hartsville
d. STREET ADDRESS Box 50 Norway Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Richard Middle: [illegible] Last: Brown
4. DATE OF DEATH Month: 9 Day: 6 Year: 1966
5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-15-1912
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herbert Brown
14. MOTHER'S MAIDEN NAME: Ida Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): [illegible] (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Pauline Hall Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [illegible] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED 9
EXAMINER'S NAME (Type)
Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-10-66
23c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor
23d. LOCATION (City, town or county) (State): Westminster Md.

24. FUNERAL DIRECTOR: William Rust ADDRESS: Union Md.
25a. REC'D BY REGISTRAR DATE: SEP 9 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
3500 4-64

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12180 12175

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7mo. 24 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): 3-#31197 — First: Michael — Middle: Joseph — Last: Brukiewa

4. DATE OF DEATH: Month: 9 — Day: 22 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEP.

8. DATE OF BIRTH: Aug. 17, 1909

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Brukiewa

14. MOTHER'S MAIDEN NAME: Ida Cieslak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Carcinoma of Floor of the mouth
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Alcoholism; Inanition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): -------

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. --- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State): ----

21. I certify that ~~(I)~~ (this hospital) attended the deceased from 1/28, 19 66, to 6/22, 1966, that (I) ~~(we)~~ last saw the deceased alive on 6/22 19 66, and that death occurred at 3:30 A. M, from causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 6/22/66

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/24/66

23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart of Mary Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore Maryland

24. FUNERAL DIRECTOR ADDRESS: John J. Duda Inc. 2829 Hudson St. Balto. Md.

25a. REC'D BY REGISTRAR DATE: SEP 27 1966

25b. REGISTRAR'S SIGNATURE: [signature]

Items 18-21 Film 382 10-2

1

FOR STATE HEALTH DEPT.

M 1218

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12176

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Five pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 a. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. STREET ADDRESS: RFD #1, Box 213

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: DANIEL — Middle: CLEMM — Last: BURTIS

4. DATE OF DEATH: Month: September — Day: 29 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-28-1928

9. AGE (In years last birthday): 38 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C+P. Telephone Co

10b. KIND OF BUSINESS OR INDUSTRY: Splicer

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Burtis

14. MOTHER'S MAIDEN NAME: Lilly Leatherbury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Amelia Galloway Burtis #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Pulmonary embolism

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Fractures of long bones of right lower leg

DUE TO

(c): and infected laceration of left lower leg.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver in truck-auto collision

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 9 17 19 66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street

20f. (City or town) Davidsonville (County) AA (State) Md.

21 **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 9/30/66

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10-1-1966

23c. NAME OF CEMETERY OR CREMATORY: ST. ANNE'S CEMETERY

23d. LOCATION (City or Town): ANNAPOLIS (County) (State): MD

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS — ADDRESS: ANNAPOLIS MD.

25a. RECD BY REGISTRAR — DATE: OCT 4 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and not later, within 72 hours after death.

VR AIS 14
15M 7-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12182 12177

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b: 17 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Plains, Maryland
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evans — Middle: ~~Eagwood~~ — Last: Caywood

4. DATE OF DEATH: Month: 9 — Day: 24 — Year: 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 4/22/1908

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ODELL CAYWOOD

14. MOTHER'S MAIDEN NAME: Virginia BASSFORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from 9/24/66 19.... to 9/25/66 19.... that I (we) last saw the deceased alive on 9/24/66 19..... and that death occurred at 2:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 9/25/66

22c. PHYSICIAN'S NAME (Type): L. BENEDICT M.D.
22d. ADDRESS: Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: ~~9/28/66~~ 9/28/66
23c. NAME OF CEMETERY OR CREMATORY: Christ Church
23d. LOCATION (City, town or county) (State): Chaptico Md

24. FUNERAL DIRECTOR'S SIGNATURE: McClafferty by Leonardtown, Md
ADDRESS

25a. REC'D BY REGISTRAR DATE: SEP 27 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12183

CERTIFICATE OF DEATH

13569

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: (none) — Last: COLLINSON
4. DATE OF DEATH: Month: September — Day: 20 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 31, 1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (County & State, or foreign country): Sudley, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William Collinson
14. MOTHER'S MAIDEN NAME: Ella Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 213 14 0607
17. INFORMANT: George W. Collinson — Address: Deale Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac standstill (arrest) — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
DUE TO
(b): Acute (anterior) myocardial infarction — 5 days
DUE TO
(c): Arteriosclerosis, general and coronary — many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus, pulmonary emphysema, congestive heart failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~the coroner~~) attended the deceased from 15 Sep, 1966, to Sept. 20 1966, that (I) (~~he~~) last saw the deceased alive on Sept. 20, 1966, and that death occurred at 11:15 AM, from causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept 20, 1966
22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M. D.
22d. ADDRESS: South River Medical Center Edgewater, Maryland 21037

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-23-66
23c. NAME OF CEMETERY OR CREMATORY: Wood Field
23d. LOCATION (City or Town) (County) (State): Galesville, Md

24. FUNERAL DIRECTOR — ADDRESS: T A Hardesty, Galesville, Md
25a. REC'D BY REGISTRAR — DATE: OCT 10 1966
25b. REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12184

CERTIFICATE OF DEATH

12179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. And in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Evergreen Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: — Last: Cooper.

4. DATE OF DEATH: Month: 9 — Day: 13 — Year: 19 66

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-13-93

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Howard T. Davenport

14. MOTHER'S MAIDEN NAME: Ella Null

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. George N. Cooper (Husband) — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Anemia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): intestinal obstruction — 4 weeks
DUE TO
(c): Carcinoma of the Colon — union

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 1966, to Sept-13, 1966, that (I) (we) last saw the deceased alive on 9-14-66 19___, and that death occurred at 11:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Franz Grell — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-14-66

22c. PHYSICIAN'S NAME (Type): Franz X. Grell

22d. ADDRESS: 5 Central Ave Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 16/66

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

23d. LOCATION (City or town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: R. Singleton — ADDRESS: Singleton funeral Home Glen Burnie, Md.

25a. RECD BY REGISTRAR DATE: SEP 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Handpiease remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12185 **CERTIFICATE OF DEATH** 12180

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: //////
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): N. Arundel Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: #7833 Americana Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JAMIE	ROBERT	CRAWFORD	Sept.	12	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Male	White	☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED	Jan. 9, 1909	57 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant	Davison Chem. Co.	Richmond, Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jamie R. Crawford Sr.	Effie Cottrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WW II	216-18-0517	Mrs. Nancy E. Crawford (wife) Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Thrombosis, acute — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral iliac arterial occlusion. Vein graft Apr. 1966 — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Nov. 19 65, to Sept 19 66, that (I) (we) last saw the deceased alive on Sept 19 66, and that death occurred at 2:30 A.M. from causes and on the date stated above.

22a. SIGNATURE: F. I. Codd — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-13-66

22c. PHYSICIAN'S NAME (Type): Francis I. Codd M.D. — 22d. ADDRESS: Severna Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 15/66	Balto. Mat'l. Cem.	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Singleton Funeral Home, Glen Burnie, Md.	SEP 15 1966	J. Charles Judge

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12181

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: Maryland
b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN — Middle HENRY — Last DAVIS

4 DATE OF DEATH: Month September — Day 17 — Year 19 66

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8-4-1920

9 AGE (In years last birthday): 46 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Paul Eugene Davis

14 MOTHER'S MAIDEN NAME: Hester Green

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 215-12-7872

17 INFORMANT: Esther Davis — Address: 10 Hicks Ave.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple Traumatic Injuries.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Driver in auto-auto collision.

20c TIME OF INJURY Hour ~~Xxx~~ p.m. Month, Day, Year: 9/17 1966

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Street

20f (City or town): A.A. (County): (State): Md.

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles Petty M.D

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: 9/18/66

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 9-22-1966

23c NAME OF CEMETERY OR CREMATORY: Pt. Pleasant

23d LOCATION (City or Town): Annapolis (County): (State): Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.

25a REC'D BY REGISTRAR DATE: SEP 20 1966

25b REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12183 — 12182

1. PLACE OF DEATH
a. COUNTY: A A Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.A.J. - Kombrough. 99

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Odenton -
d. STREET ADDRESS: 543 Maple Ridge RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Grace — Last: Deering

4. DATE OF DEATH: Month: 9 — Day: 14 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept, 8 1899

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Receptionest

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Salerno, Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ferdinand Russo (Deceased)

14. MOTHER'S MAIDEN NAME: Anna G. ~~Mi~~ Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 004-05-3810

17. INFORMANT: Mr. Lawrence Deering, Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
7344

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 9-14-66

23a. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Sept. 17, 1966

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City or Town) (County) (State): Portland, Maine

24. FUNERAL DIRECTOR: Harold S. Wade, ADDRESS: 550 Wash. Blvd., Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 16 1966

25b. REGISTRAR'S SIGNATURE: Wesley Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M 12139

CERTIFICATE OF DEATH

12183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c LENGTH OF STAY IN 1b: 26 yrs. 1mo. 27 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Prince George
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☐ Unknown

3. NAME OF DECEASED (Type or print): 3-#06871 — First: Louise — Middle: — Last: Deville
4. DATE OF DEATH: Month 9 — Day 1 — Year 1966
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1911
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (County & State, or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Deville
14. MOTHER'S MAIDEN NAME: Alice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes give war or dates of service)
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Due: Decubitus Ulcers
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Bilateral Amputation
Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia-Paranoid, Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 -----
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State) -----

21. I certify that (I) (this hospital) attended the deceased from 7/4, 19 40 to 9/1, 19 66, that (I) (we) last saw the deceased alive on 9/1, 19 66, and that death occurred at 10:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Lionel McHenry Mapp, M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/1/66
22c. PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): 9/5/66
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Forest Hill
23d. LOCATION (City or Town) (County) (State): Clinton Md

24. FUNERAL DIRECTOR: Rollins — ADDRESS: 4339-Hunt PL
25a. RECD BY REGISTRAR DATE: SEP 6 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12189 12184

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie(Marley Pk.)
c. LENGTH OF STAY IN 1b: 6mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 203 Summit Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, (Marley Pk.)
d. STREET ADDRESS: 203 Summit Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MILDRED Middle: M. Last: DINGLEY

4. DATE OF DEATH: Month, Day, Year: September 2 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 28 July 1899

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (unknown) Atwood

14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Catherine Weigand -Same as # 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis - Abdomen — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 1942
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhart M.D.

EXAMINER'S NAME (Type): E. Linhart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 9/2/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5 Sept. 66

23c. NAME OF CEMETERY OR CREMATORY: Our Lady Catholic Cemetery Millersville, Md.

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR ADDRESS: Robert F. Wise Singleton Funeral Home/Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5) 5M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12198 — 12185

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
   c. LENGTH OF STAY IN 1b: 34 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
   d. STREET ADDRESS: 1812 Penrose Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): #03682 — First: Carrie — Middle: — Last: Dixon

4. DATE OF DEATH: Month: Sept. — Day: 22nd — Year: 1966

5. SEX: Female

6. COLOR OR RACE: Ny

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/11/1893

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — —

10b. KIND OF BUSINESS OR INDUSTRY: — — —

11. BIRTHPLACE (County & State or foreign country): — — —

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY.
   IMMEDIATE CAUSE (a): Cancer of Breast. — INTERVAL BETWEEN ONSET AND DEATH: 1 year
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): — DUE TO
   (c): —

   PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — — — — — — — —

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — — 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) — (County) — (State) — — —

21. I certify that (I) (this hospital) attended the deceased from 9/1, 1932, to 9/22, 1966, that (I) (we) last saw the deceased alive on 9/22 1966, and that death occurred at 5:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Alvin Thompson — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/22/66.

22c. PHYSICIAN'S NAME (Type): Alvin Thompson

22d. ADDRESS: Crownsville State Hosp.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 9.30.66

23c. NAME OF CEMETERY OR CREMATORY: U of Md Med School

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR — ADDRESS: W Reese F 108 N Main ST

25a. REC'D BY REGISTRAR DATE: OCT 5 1966

25b. REGISTRAR'S SIGNATURE: Marie Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2 infor taken from birth cert.

12191

CERTIFICATE OF DEATH

12186

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G. MEADE
c. LENGTH OF STAY IN 1b: NA
d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospitol, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIOENCE (Where deceosed lived, if institut on: Residence before odmission)
a. STATE: /NA/ Md. — b. COUNTY: /NA/ A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): /NA// Glen Burnie
d. STREET ADDRESS: NA 1019 Genine Dr.
e. IS RESIDENCE ON A FARM? YES NA NO ☐

3. NAME OF OECEASEO (Type or print): First (NOT NAMED) — Middle — Lost DOMINICK
4. OATE OF OEATH: Month September — Doy 2, — Year 1966
5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ NA DIVORCED ☐
8. DATE OF BIRTH: September 2,1966
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 1 / Min 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA
10b. KIND OF BUSINESS OR INDUSTRY: NA
11. BIRTHPLACE (County & State, or foreign country): ANNE ARUNDEL, MARYLAND
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: JOHN A. DOMINICK
14. MOTHER'S MAIDEN NAME: GRACE SUTTLES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NA (If yes give war or dates of service): NA
16. SOCIAL SECURITY NO.: NA
17. INFORMANT: JOHN A. DOMINICK — Address: 1019 Genine Drive, Glen Burnie, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF OEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSEO BY
IMMEDIATE CAUSE (a): Asphyxia neonatorum — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.55min
DUE TO
Conditions, if ony, which gove nse to immediote couse (a), stoting the underlying couse last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONDITION GIVEN IN PART I(a): NA
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NA
20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.): NA
20c. TIME OF INJURY Month, Ooy, Year, Hour o.m. p.m.: NA 19
20d INJURY OCCURREO While ot work ☐ Not While ot work NA ☐
20e PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): NA
20f (City or town) (County) (Stote): NA

21. I certify thot (I) ~~[illegible]~~ attended the deceased from September 2 1966, to September2 1966, that (I) (xx) last saw the deceosed alive on 2 September 1966, and that death occurred at 9:00aM, from couses and on the date stoted above.

22a SIGNATURE: THEODORE F. TOULAN M.D — ATTENDING PHYS ☐ MED. OIRECTOR ☐ STAFF PHYS ☒
22b. OATE SIGNEO: September 2,1966
22c PHYSICIAN'S NAME (Type): THEODORE F. TOULAN, M.D.
22d. ADDRESS: Kimbrough Army Hosp, Ft G G Meade, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: September6,1966
23c. NAME OF CEMETERY OR CREMATORY: Kimbrough Army Hospital
23d LOCATION (City or Town) (County) (State): Ft G G Meade,Anne Arundel,Md.

24. FUNERAL OIRECTOR: Jonathan Roberts, CPT,MSC,Kimbrough AH,Ft G. G. Meade, Md.
ADDRESS
25a. REC'O BY REGISTRAR — OATE: SEP 14 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12192 — 12187

1. PLACE OF DEATH — a. COUNTY: A.A. MARYLAND — MARYLAND: FOUND DEAD FORT GEORGE G. MEADE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEO G MEADE, MD
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL, FGGMMD

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) — a. STATE: MARYLAND — b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ST MICHAELS, MARYLAND
d. STREET ADDRESS: GRACE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARY — Middle: JO — Last: DYOTT

4. DATE OF DEATH: FOUND DEAD — Day: 3 — Month: SEPT — Year: 66 19

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 SEPT 1948

9. AGE (In years last birthday): 17 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): ST MICHAELS, TALBOT, MD.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ERNEST W. DYOTT

14. MOTHER'S MAIDEN NAME: CATHERNE BALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: ERNEST W. DYOTT:GRACE ST, ST MICHAELS,MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): BLUNT FORCE HEAD INJURIES; ASSOCIATED MANUAL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(b): STRANGULATION
(c):

INTERVAL BETWEEN ONSET AND DEATH: FOUND DEAD 3 SEPT 66

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
HOMICIDAL ASSAULT BY ANOTHER

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that [redacted] was DOA, [redacted], that (I) (We) last saw the deceased alive [redacted] death occurred at 8:05PM, from causes and on the date stated above.

22a. SIGNATURE: Henry M. Snell M.D — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 6 SEPT 66

22c. PHYSICIAN'S NAME (Type): HENRY M. SNELL, CPT, MC, USA

22d. ADDRESS: 1ST US ARMY LABORATORY, FGGMMD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 6, 1966

23c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery

23d. LOCATION (City or Town) (County) (State): St. Michaels, Talbot Co.,Md.

24. FUNERAL DIRECTOR — ADDRESS: Hampton Harrison, St. Michaels, Md

25a. REC'D BY REGISTRAR — DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12193

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12188

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore-rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: South Carolina
b. COUNTY: Horry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conway
d. STREET ADDRESS: 1506 3rd Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: John — Middle: D. — Last: Edmondson

4 DATE OF DEATH: Month: 9 — Day: 17 — Year: 19 66

5 SEX: male

6 COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: May 19,1928

9 AGE (In years last birthday): 38 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painting Contractor

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Horry County, S.C.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: John D. Edmondson

14 MOTHER'S MAIDEN NAME: Theresa Johnson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): World War 2

16 SOCIAL SECURITY NO:

17 INFORMANT: Charles Edmondson — Address: Myrtle Beach

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): pedestrian struck by car

20c TIME OF INJURY Month, Day, Year: Hour 11:00 p.m. — 9 17 1966

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street

20f (City or town) (County) (State): Balto.-rural A.A. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz MD

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 9/19/66

23a BURIAL, CREMATION, REMOVAL (Specify): Removal

23b DATE THEREOF: Sept. 20, 1966

23c NAME OF CEMETERY OR CREMATORY: Union Methodist Cemetery

23d LOCATION (City or Town) (County) (State): Myrtle Beach — S.C.

24 FUNERAL DIRECTOR: William J. Tickner & Sons — ADDRESS: N. & Pa. Aves.

25a RECD BY REGISTRAR DATE: SEP 20 1966

25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12194 — 12189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 1004 Phillip Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Freeborough — Last EKSTROM, Sr.

4. DATE OF DEATH: Month September — Day 20 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 15, 1899

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chauffer (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Shipley Trans.

11. BIRTHPLACE (County & State, or foreign country): State of Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Ekstrom

14. MOTHER'S MAIDEN NAME: Emma Freeborough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 212-10-6356

17. INFORMANT: Mr. Carroll L. Ekstrom (Son) — Address: 616 NewJersey Ave. Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 12 HOURS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): VIRAL HEPATITIS — 21 DAYS
DUE TO
(c): TERMINAL UREMIA — 24 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (the ~~physician~~) attended the deceased from SEPT 1, 1966, to Sept. 20, 19 66 that (I) ~~(he)~~ last saw the deceased alive on Sept. 20 19 66, and that death occurred at 7:00 PM, from causes and on the date stated above.

22a. SIGNATURE: Arthur Lankford Jr. — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-21-66

22c. PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR.

22d. ADDRESS: 2134 MOUNTAIN RD. PASADENA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 24, 66

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: Richard V. Singleton

ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12195 — 12196

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena, Rt. 7
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Oakdale Rd., Pinehurst on Bay

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena Rt. 1, Box 63
d. STREET ADDRESS: Oakdale Road, Pinehurst on Bay
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: P. — Last: Finn, Sr.

4. DATE OF DEATH: Month: Sept. — Day: 21 — Year: 19[illegible]

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		12-7-88	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Projectionist	Motion Pictures	Maryland	U.S.A.

13. FATHER'S NAME: John Finn

14. MOTHER'S MAIDEN NAME: Katherine Zerves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214035486A

17. INFORMANT — Address: Mrs. Marie C. Finn, 840 Evesham Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: IMMED.
DUE TO (b): rheumatic heart disease — 50-60 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): pneumonitis, bacterial

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): pneumonitis, bacterial

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/9/66 ..... 19[illegible] to 9/21 ..... 19[illegible], that (I) (We) last saw the deceased alive on 9/21/ ..... 19[illegible], and that death occurred at 8 A M. from the causes and on the date stated above.

22a. SIGNATURE: C. Earl Hill M D

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): C. Earl Hill, M.D.

22d. ADDRESS: 395 Ft. Smallwood Rd. Pasadena, Md. 21122

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	9/24/66	Holy Redeemer	Balto., Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leonard J. Ruck, Inc., Balto., Md. 21214

25a. REC'D BY REGISTRAR DATE: SEP 23 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M S-65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12196

CERTIFICATE OF DEATH

12191

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 6 yrs. 4 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Children's Center Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 1541 - 1st Street, S. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maureen — Middle: O. — Last: Fowler
4. DATE OF DEATH: Month: Septembeer — Day: 26 — Year: 1966
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/2/59
9. AGE (If under 1 year last birthday): 6 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Milton Otis Fowler
14. MOTHER'S MAIDEN NAME: Austine Sylvia Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Children's Center Hospital, Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: One day
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hydrocephalus - severe — Birth
DUE TO
(c): Mental retardation - severe

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 19, 1960, to Sept. 26, 1966, that (I) (we) last saw the deceased alive on Sept. 26, 1966, and that death occurred at 12:20 pm, from causes and on the date stated above.

22a. SIGNATURE: James E. Boyland M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: September 27, 1966
22c. PHYSICIAN'S NAME (Type): JAMES E. BOYLAND, M. D.
22d. ADDRESS: Children's Center Hospital, Laurel, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 1, 1966
23c. NAME OF CEMETERY OR CREMATORY: Children's Center
23d. LOCATION (City or Town) (County) (State): Laurel, A. A. Md.
24. FUNERAL DIRECTOR: [illegible] ADDRESS: Laurel Md.
25a. REC'D BY REGISTRAR DATE: OCT 3 1966
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12197 12192

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S-63

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G. MEADE, MD
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL, FGGM

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE, MD
d. STREET ADDRESS: 1830-B Forrest Ave Ft Geo G. Meade, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLEN — Middle: ROSIANE — Last: GEISELHARDT

4. DATE OF DEATH: Month: SEPT — Day: 1 — Year: 19 66

5. SEX: F

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 16 SEPT 56

9. AGE (In years last birthday): 9 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): EGGENSTEIN, GER

12. CITIZEN OF WHAT COUNTRY?: GERMAN

13. FATHER'S NAME: KENNETH A. UNDERWOOD /SF/

14. MOTHER'S MAIDEN NAME: ANNA GEISELHARDT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MRS KATHRYN HELDT Box 117 Orion, Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation
DUE TO (b): Smoke Inhalation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Smoke Inhalation

20c. TIME OF INJURY: Hour 3:20 a.m. p.m. — Month, Day, Year: 1 SEPT 19 66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) (County) (State): FT GEO G, MEADE, MD

21. I certify that (I) ~~(the hospital) attended the deceased from~~ was DOA, ~~at~~, ~~on~~ 1 SEPT, 1966, that (I) ~~(we)~~ last saw ~~the deceased alive on~~ and that death occurred at 3:20 M, from the causes and on the date stated above.

22a. SIGNATURE: Henry M. Snell M.D

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1 SEPT 66

22c. PHYSICIAN'S NAME (Type): HENRY M, SNELL, Capt, MC

22d. ADDRESS: KIMBROUGH ARMY HOSPITAL, FGGM

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6 Sept 1966

23c. NAME OF CEMETERY OR CREMATORY: SWEDONA LUTHERN CEMETERY

23d. LOCATION (City, town or county) (State): ORION, ILLINOIS

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harold D. Wade, 550 Wash. Blvd., Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 7 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12198 — 12193

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — C.2-1
d. STREET ADDRESS: 8 monroe Ct
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Emma — Middle: Esmann — Last: Gillis

4. DATE OF DEATH: Month: Sept — Day: 4 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 9/4/01

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical Work

10b. KIND OF BUSINESS OR INDUSTRY: Nat. Security Agency

11. BIRTHPLACE (County & State, or foreign country): Washington D.C.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Esemann

14. MOTHER'S MAIDEN NAME: Clara Edna Lee

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16 SOCIAL SECURITY NO.:

17. INFORMANT: Elizabeth Dixon — Address: Annapolis md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Rheumatic Heart Disease & mitral Stenosis — 7 YEARS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
HMX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardiovascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 8/24, 1966, to 9/4, 1966, that (I) (we) last saw the deceased alive on 9/4 1966, and that death occurred at 5:00 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert O. Bierin — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 9/4/66

22c. PHYSICIAN'S NAME (Type): Robert O. BIERIN

22d. ADDRESS: 121 Cathedral St, Annapolis MD

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 9/7/66

23c. NAME OF CEMETERY OR CREMATORY: CONGRESSIONAL

23d LOCATION (City or Town) (County) (State): WASH. D. C.

24 FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: 3rd & 4th ST. N.E. Washington.

25a. REC'D BY REGISTRAR DATE: SEP 8 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12199

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12194

1 PLACE OF DEATH
a. COUNTY: AA
b. STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA when brought to AAGH

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: AA.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: Rt. 1 Box 138
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Henry W. Middle: Last: Goetz
4. DATE OF DEATH: Month: 9 Day: 3 Year: 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/10/84
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Costume Business
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Goetz
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 213-34-8616
17. INFORMANT: Address: Mr. Joseph Peroutka, 6208 Traymore Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary - Sudden — INTERVAL BETWEEN ONSET AND DEATH: instant
DUE TO
(b): (Collapsed at home on floor)
DUE TO
(c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: —
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18): No injury
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles H. Wirth MD M.D
EXAMINER'S NAME (Type): Charles H. Wirth M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county):

22. DATE SIGNED: 9/3/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/7/66
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City or Town) (County) (State): Balto., Md.

24. FUNERAL DIRECTOR ADDRESS: Leonard J. Ruck, Inc. 5305 Harford Rd.
25a. RECD BY REGISTRAR DATE: SEP 6 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12209 — 12195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): N. Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS: Rt.#1 Box 188(Elvaton Rd.)
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES — Middle F. — Last HACKMAN

4. DATE OF DEATH: Month Sept. — Day 27, — Year 1966

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 2, 1908
9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Self- Employed
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hackman
14. MOTHER'S MAIDEN NAME: Amelia Strobel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mrs. Florence Hackman (Wife) Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO (b): Arteriosclerotic Heart Disease — 4201 — 4 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-19, 1966, to 9-27, 1966, that (I) (we) last saw the deceased alive on 9-27 1966, and that death occurred at 2:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: H. T. O'Herlihy M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 9-27-66
22c. PHYSICIAN'S NAME (Type): H. T. O'HERLIHY M.D.
22d. ADDRESS: 5 Central Ave, Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 30, 66
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Richard V. Singleton Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 29 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12201 12196

1. PLACE OF DEATH
a. COUNTY A. A. Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. MARGARETS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BAY MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MD. b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
d. STREET ADDRESS 9 SOUTHGATE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First KATRINA Middle LOOMIS Last Halligan
4. DATE OF DEATH Month SEPT Day 2 Year 1966
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-11-1876
9. AGE (In years last birthday) 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (County & State, or foreign country) ERIE, Pa.
12. CITIZEN OF WHAT COUNTRY U.S.
13. FATHER'S NAME JOEL PORTER LOOMIS
14. MOTHER'S MAIDEN NAME KATE HASKINSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address MRS. CHARLES ADAIR #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — Unknown
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~this hospital~~ attended the deceased from 12/2, 1965, to 9/2, 1966, that (I) ~~(we)~~ last saw the deceased alive on 8/26 1966, and that death occurred at 6 P M, from the causes and on the date stated above.

22a. SIGNATURE Richard L. Hochman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 9/3/66
22c. PHYSICIAN'S NAME (Type) Richard L. Hochman, M.D.
22d. ADDRESS 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 9-6-1966
23c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY
23d. LOCATION (City, town or county) (State) ANNAPOLIS MD.
24. FUNERAL DIRECTOR ADDRESS JOHN M. TAYLOR SONS ANNAPOLIS MD
25a. REC'D BY REGISTRAR DATE SEP 7 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12202 12197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 917 Creek Drive

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 917 Creek Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Irene — Last: Hallock
4. DATE OF DEATH: Month: September — Day: 27 — Year: 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 9, 1898
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): SHADY SIDE, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN A. HALLOCK
14. MOTHER'S MAIDEN NAME: SARAH V. PROUT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. P.J. NEIMILLER — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute dilatation of the heart — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Colitis (Chronic)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXXX~~) attended the deceased from 6/2/ 19 66, to 9/27/ 19 66, that (I) (~~XXX~~) last saw the deceased alive on 9/27 19 66, and that death occurred at 6:07 M, from causes and on the date stated above.

22a. SIGNATURE: Albert L. Anderson — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/28/66
22c. PHYSICIAN'S NAME (Type): Albert L. Anderson, M.D.
22d. ADDRESS: 44 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-29-66
23c. NAME OF CEMETERY OR CREMATORY: Quaker Burying Ground
23d. LOCATION (City or Town) (County) (State): WEST RIVER MD.

24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor & Sons Annapolis, Md.
25a. REC'D BY REGISTRAR — DATE: SEP 29 1966
25b. REGISTRAR'S SIGNATURE: H. Charles Judge

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12203

CERTIFICATE OF DEATH

12198

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie, Md.
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25, Maryland
d. STREET ADDRESS: 5115 Patrick Henry Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: J. — Last: Haney
4. DATE OF DEATH: Month: September — Day: 15 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/25/07
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Backhoe operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Nimrod Haney
14. MOTHER'S MAIDEN NAME: Ada F McDaniel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW 11
16. SOCIAL SECURITY NO.: 214-01-7791
17. INFORMANT: Mrs. Leona Braun — Address: 5115 Patrick Henry Drive (sister)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Pulmonary Emphysema
DUE TO (c): Congestive Heart Failure & Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4341
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 6, 1966 to September 15, 1966, that (I) (we) last saw the deceased alive on September 15 1966, and that death occurred at 8:10 PM, from causes and on the date stated above.

22a. SIGNATURE: Earl Evans A. Evans M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/19/66
23c. NAME OF CEMETERY OR CREMATORY: Parkwood
23d. LOCATION (City or Town) (County) (State): Baltimore Maryland

24. FUNERAL DIRECTOR — ADDRESS: Leonard J Ruck Inc. 5305 Harford Rd
25a. REC'D BY REGISTRAR — DATE: SEP 19 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12204

CERTIFICATE OF DEATH

12199

1 PLACE OF DEATH
a. COUNTY: Carroll (A.K.A. County Home, Hoover Mundal Hosp) MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): E. Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
d. STREET ADDRESS: Rt #2 Box 109 Carrol Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Charles Middle Ralph Last Harrison
4. DATE OF DEATH: Month Sept Day 7 Year 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-7-10
9. AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wax man
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Tyson C. Harrison
14. MOTHER'S MAIDEN NAME: Rachel Steffey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 216-07-4221
17. INFORMANT: Mrs. Fearn Harrison Address: Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Myocardial infaction — 2 day
DUE TO
(c): ASCVHD — year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/5/66, 19__ to 9/7/66, 19__, that (I) (we) last saw the deceased alive on 9/7/66 19__, and that death occurred at 900 M, from causes and on the date stated above

22a. SIGNATURE: David Abramson M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/8/66
22c. PHYSICIAN'S NAME (Type): David Abramson
22d. ADDRESS: 707 Balto Annap Blvd

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/10/66
23c. NAME OF CEMETERY OR CREMATORY: Finksburg Cemetery
23d. LOCATION (City or Town) (County) (State): Finksburg, Md.

24. FUNERAL DIRECTOR: J. F. Eline & Sons ADDRESS: Reisterstown Md.
25a. REC'D BY REGISTRAR DATE: SEP 13 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12205

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12200

1 PLACE OF DEATH
a. COUNTY: A. A. CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis.
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - ANNE-ARUNDEL - General

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD
b. COUNTY: A A Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~xxxxxxxxx~~ Mayo
d. STREET ADDRESS: ~~xxxxxxxx~~ Shoreham Beach Rd.
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James. Middle: Dudley Last: Harty

4. DATE OF DEATH: Month: 9 Day: 27 Year: 19 66

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 1-3-09

9 AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. shipping dept.

10b KIND OF BUSINESS OR INDUSTRY: U.S.N.

11 BIRTHPLACE (State or foreign country): Washington, D. C.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: James Harty

14 MOTHER'S MAIDEN NAME: Eleanor Maney

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II

16 SOCIAL SECURITY NO: 577-01-6403

17. INFORMANT: Mrs. Wilma S. Harty Address: Shoreham Beach Rd. Mayo, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
4344
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D.

EXAMINER'S NAME (Type): E. Linhardt. - Annapolis, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 9-27-66.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Sep. 30, 1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: John B. Thomas Warner E. Purpfrey, Inc.

ADDRESS: John B Thomas 8434 Georgia Ave. Silver Spring, Md.

25a RECD BY REGISTRAR DATE: SEP 30 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12206 12201

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6213 - 60th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR — Middle C. — Last HISE

4. DATE OF DEATH: Month September — Day 21 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 22, 1888

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U S Government

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Hise

14. MOTHER'S MAIDEN NAME: Louise Kopp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give war or dates of service): W W I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ruth Reisinger — Address: Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing Chest Injuries
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Head on collision - Driver

20c. TIME OF INJURY: Hour 9:40 a.m. — Month, Day, Year: 9/21 1966

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town): Anne Arundel — (County) — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: 9/21/66

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 24, 1966

22c. NAME OF CEMETERY OR CREMATORY: George Washington

22d. LOCATION (City, town, or country): Hyattsville, Md. — (State)

23. FUNERAL DIRECTOR: F. Gaseh's Sons — ADDRESS: Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: SEP [illegible] 1966

24b. REGISTRAR'S SIGNATURE: [illegible] by Snyder

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12207 — 12202

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills,
   d. STREET ADDRESS: Rutland Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emily — Middle: Summerville — Last: Hopkins

4. DATE OF DEATH: Month: Sept. — Day: 28 — Year: 19 66

5. SEX: female — 6. COLOR OR RACE: white — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 7, 1885

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public High School

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Snowden Hopkins

14. MOTHER'S MAIDEN NAME: Elizabeth Linthicum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-48-4937-T

17. INFORMANT — Address: Nancy P. Hopkins -sister same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ① Coronary Acute dilatation of Heart

DUE TO (c): ② Chronic Cholitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/11/54, 19 —, to 9/27, 1966, that (I) (we) last saw the deceased alive on 9/26/, 19 66, and that death occurred at 5:01 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Albert L. Anderson — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ALBERT L. ANDERSON-M.D. — 22d. ADDRESS: ANNAPOLIS, M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Sept. 30, 1966 — 23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Cemetery — 23d. LOCATION (City, town or county) (State): Millersville Md.

24a. FUNERAL DIRECTOR: Beverley L. Hopping — ADDRESS: Beverley L. Hopping Annapolis, Md.

HOPPING FUNERAL HOME

25a. REC'D BY REGISTRAR — DATE: OCT 3 1966 — 25b. REGISTRAR'S SIGNATURE: J. Harley Judge

VR A15 (4)
15M 4-64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. In any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12208 **CERTIFICATE OF DEATH** 12203

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: New York — b. COUNTY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hartsdale
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital	d. STREET ADDRESS: 88 Charlot Place — e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Miriam	Adams	HOWE	September	29	19 66

5 SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	White		Feb. 28, 1879	87 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOMEMAKER	Virginia	U.S.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES ADAMS	MARY LITCHFIELD

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT Address
NO		HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12-0

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Hypertension +

DUE TO (c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) ~~XXXXXXXX~~ attended the deceased from 9-11-19___, to Sept. 29, 1966, that (I) ~~XXX~~ last saw the deceased alive on Sept. 29 1966, and that death occurred at 12:15 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
E.M. Shipley		9-30-66

22c PHYSICIAN'S NAME (Type)	22d. ADDRESS
E.M. SHIPLEY	121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-2-1966	JUNE CEMETERY	W. SALEM WESTCHESTER NY

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOHN M. TAYLOR SONS ANNAPOLIS MD.	OCT 4 1966	J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12204

1 PLACE OF DEATH
a. COUNTY: AACo. — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Arnold Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 1002 Park Place

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: AACo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold Beach
d. STREET ADDRESS: 1002 Park Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Melvin — Middle J. — Last Hyser

4. DATE OF DEATH: Month 9 — Day 23 — Year 1966

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: 8/4/08

9 AGE (In years last birthday): 58 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician

10b KIND OF BUSINESS OR INDUSTRY: Entertainment

11 BIRTHPLACE (State or foreign country): Md

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Harry M

14 MOTHER'S MAIDEN NAME: Mary Proctor

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I

16 SOCIAL SECURITY NO: 213-09-9820

17 INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerosis
DUE TO (b): Chronic Alcoholism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D.

EXAMINER'S NAME (Type): E. Linhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22 DATE SIGNED: 9.13.66

23a. BURIAL, CREMATION, REMOVAL (Specify): B

23b. DATE THEREOF: 9-27-66

23c. NAME OF CEMETERY OR CREMATORY: Catholic

23d LOCATION (City or Town) (County) (State): Balto. Md.

24. FUNERAL DIRECTOR: McCurley — ADDRESS: 1330 E Fort Ave.

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1 M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1221A 12205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: A. A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Anna Polis
   c. LENGTH OF STAY IN 1b: 4 Mos.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Manor N/Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: A. A. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   d. STREET ADDRESS: 611 Delaware Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: J. — Last: Keller ~~Kellar~~

4. DATE OF DEATH: Month: Sept. — Day: 9 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10 June 1881

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Scheerer

14. MOTHER'S MAIDEN NAME: Mary Nizer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-56-0087

17. INFORMANT: Elsie P. Keller — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Cerebral arteriosclerosis — unknown
   331 X
   DUE TO (c):
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/21, 1966 to 9/2, 1966, that (I) ~~(we)~~ last saw the deceased alive on 9/2 1966, and that death occurred at 10:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard F. Hochman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9/3/66

22c. PHYSICIAN'S NAME (Type): Richard F. Hochman, MD — 22d. ADDRESS: 59 Franklin St. Annapolis Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9/6/66 — 23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial Pk — 23d. LOCATION (City, town or county) (State): Howard Co.

24. FUNERAL DIRECTOR — ADDRESS: Robert Vease Singleton Funeral Home Glen Burnie Md — 25a. REC'D BY REGISTRAR DATE: SEP 7 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12206

1 PLACE OF DEATH
a COUNTY: All Co. — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN (Glen Burnie)
c. LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - North. Arundel. Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: MD — b COUNTY: Anne.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Summerset. Road - Severn. MD
d STREET ADDRESS: Box - 193-A - Rt 3 - 21144
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	M	Knott	9	15	19 66

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
M	W		10-27-00	65 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife		Pa.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
E. M. Lockard	Annie E. Nash

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT Address
No	170-12-3237	Raymond W. Knott - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part I of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 9-15-66.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	19 Sept. 66	Glen Haven Memorial Pk.	Glen Burnie Anne Arundel Co. Md.

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Singleton Funeral Home / Glen Burnie, Md.	SEP 19 1966	J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12207

1. **PLACE OF DEATH**
   a. COUNTY: A.A. Co — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): O.O.A – North. Arundel – Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore –
   d. STREET ADDRESS: 1533 Tunlow. Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Bernard — Middle: W. — Last: Kolodzi

4. **DATE OF DEATH**: Month: 9 — Day: 25 — Year: 19CC

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/12/17

9. AGE (In years last birthday): 49 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WELDER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Kolodzi

14. MOTHER'S MAIDEN NAME: KATHERINE ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES. (If yes give war or dates of service): W W I

16. SOCIAL SECURITY NO: 216-07-9752

17. **INFORMANT** Address: MRS. ANNA I. Kolodzi (SAME)

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY
   IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO (b):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):
   4344

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D

EXAMINER'S NAME (Type): E Linhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 9.27.66

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9/28/66.

23c. NAME OF CEMETERY OR CREMATORY: DULANEY VALLEY CEM.

23d. LOCATION (City or Town) (County) (State): BALTIMORE Md.

24. FUNERAL DIRECTOR ADDRESS: LEONARD J. RUCK, INC. BALTO. MD. 21214

25a. RECD BY REGISTRAR DATE: SEP 29 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12213 — 12208

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIII (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND — 6 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
d. STREET ADDRESS: #210 Harlem Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN — Middle V. — Last KREIDER
4. DATE OF DEATH: Month SEPT — Day 11 — Year 1966
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 11, 1910
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Max Votel
14. MOTHER'S MAIDEN NAME: Freida Singer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: None — Address: Mr. Harry E. Kreider (Husband) Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PRIMARY BRONCHOGENIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 3 MONTHS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CORONARY ARTERY DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1958, 19.., to 1966, 19....., that (I) (~~we~~) last saw the deceased alive on SEPT 10 1966, and that death occured at 2:?? M, from the causes and on the date stated above.

22a. SIGNATURE: Arthur Lankford Jr. MD — M.D.
22c. PHYSICIAN'S NAME (Type): ARTHUR LANKFORD, JR., M. D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS:
22b. DATE SIGNED: 9-11-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 14 66
23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park
23d LOCATION (City, town or county): Howard Co.
(State): Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: B. Fleming
ADDRESS: Singleton Funeral Home, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: SEP 13 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12214

CERTIFICATE OF DEATH

12208

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Severna Park
d. STREET ADDRESS: Rt-2, Box-417
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fred — Middle: Newton — Last: LANDON

4. DATE OF DEATH: Month: September — Day: 28 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 14, 1879

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ret. machinist

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State or foreign country): Morral — Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Lymon Landon

14. MOTHER'S MAIDEN NAME: Olive Eager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 716-12-1541

17. INFORMANT — Address: Harry E. Landon-son same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinomatosis. —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~xxxxxxxx~~) attended the deceased from June 1966, 19___, to Sept. 28 1966, that (I) (~~xxx~~) last saw the deceased alive on Sept. 28 19 66, and that death occurred at 1:30 PM, from causes and on the date stated above.

22a. SIGNATURE: T. G. Osius M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/28/66

22c. PHYSICIAN'S NAME (Type): T. G. Osius, M.D.

22d. ADDRESS: 77 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-removal

23b. DATE THEREOF: Oct. 1, 1966

23c. NAME OF CEMETERY OR CREMATORY: West Side Cemetery

23d. LOCATION (City or Town) (County) (State): Shamokin Dam Snyder Pa.

24. FUNERAL DIRECTOR: Beverley E. Hopping — HOPPING FUNERAL HOME
ADDRESS: Beverley E. Hopping Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12215 — 122111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANOVER
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): FOREST AVE,

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANOVER
d. STREET ADDRESS: FOREST AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MORLEY — Middle H. — Last LEATHERWOOD

4. DATE OF DEATH: Month 9/28 — Day — Year 1966

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 12/19/96 — 9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK — 10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R. — 11. BIRTHPLACE (County & State, or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: JOSHUA LEATHERWOOD — 14. MOTHER'S MAIDEN NAME: AUGUSTA HOOP

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: 705 07 2464 — 17. INFORMANT: RUTH LEATHERWOOD — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a):
DUE TO (b): Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Extensive Metastasis to Liver — 8 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 28 19 66 to Sept 29, 19 66, that (I) (we) last saw the deceased alive on Sept 28 19 66, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Frederic J. Butler M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Sept 29 1966

22c. PHYSICIAN'S NAME (Type): FREDERIC J. BUTLER — 22d. ADDRESS: 1014 Fredericks Ave Baltimore Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 10/1/66 — 23c. NAME OF CEMETERY OR CREMATORY: ZION — 23d. LOCATION (City, town or county) (State): HOWARD CO.

24. FUNERAL DIRECTOR'S SIGNATURE: E.S. MacNabb — ADDRESS: 301 FREDERICK Rd 21228

25a. REC'D BY REGISTRAR DATE: OCT 3 1966 — 25b. REGISTRAR'S SIGNATURE

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12216 — 12211

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: M. — Last: Lederhos
4. DATE OF DEATH: Month: 9 — Day: 7 — Year: 1966
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-22-1878
9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State, or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Jacob M. Lederhos
14. MOTHER'S MAIDEN NAME: Maria Schell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Otelia L. Miller — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~has hospital~~) attended the deceased from 8/26, 1966, to 9/7, 1966, that (I) (~~me~~) last saw the deceased alive on 9/6 1966, and that death occurred at 6 P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/9/66
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-10-66
23c. NAME OF CEMETERY OR CREMATORY: Asbury
23d. LOCATION (City or Town) (County) (State): Arnold A.A. Md.
24. FUNERAL DIRECTOR: John M. Taylor & Son — ADDRESS: Annapolis, Md.
25a. RECD BY REGISTRAR DATE: SEP 13 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

12217

Items 13,14 Film G381 5/26/66 mh

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12212

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shady Side
d. STREET ADDRESS: Avalon Shores
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Eugene Middle: Last: LEE
4. DATE OF DEATH Month: September Day: 12 Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 6, 1904
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Shadyside Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Elizabeth Lee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 216185880
17. INFORMANT Address: Gladys Lee, Shadyside Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

		Interval between onset and death
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia	2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Waldenstroem's macroglobulinemia	4 years
DUE TO (c)	- - - - - - - - - -	- - - -

732X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia

19. WAS AUTOPSY PERFORMED? YES XX NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (XXXXXXX) attended the deceased from Sept. 2, 1966, to Sept. 12, 1966, that (I) (XXX) last saw the deceased alive on Sept. 12 1966, and that death occurred at 5:15 XX M, from causes and on the date stated above.

22a. SIGNATURE: Charles W Kinzer M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 12, 1966
22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M.D.
22d. ADDRESS: South RivMedCent., Edgewater, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-14-66
23c. NAME OF CEMETERY OR CREMATORY: Woodfield
23d. LOCATION (City or Town) (County) (State): Galesville A.A. Md.
24. FUNERAL DIRECTOR: Bernard Hardesty ADDRESS: Galesville Md.
25a. REC'D BY REGISTRAR DATE: SEP 20 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12218 **CERTIFICATE OF DEATH** 12213

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Rt-2, Box-85
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Edith — Middle: I. — Last: LEITCH

4 DATE OF DEATH: Month: September — Day: 21 — Year: 19 66

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 4, 1898
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State or foreign country): EDGEWATER, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Floyd W. KIRBY
14. MOTHER'S MAIDEN NAME: SARAH LEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: PRESTON D. LEITCH — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 30 MINUTES
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): HYPERTENSIVE CARDIO-VASCULAR DIS — 15 YEARS
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~have attended~~) attended the deceased from APRIL, 1957, to Sept. 21, 1966 that (I) (~~we~~) last saw the deceased alive on Sept. 21 1966, and that death occurred at 9:50 AM, from causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 9-21-66
22c. PHYSICIAN'S NAME (Type): Edward S. Beck, M.D.
22d. ADDRESS: 73 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-23-66
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest
23d LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: John M. Ly Lee & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: SEP 22 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12214

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. GEN. HOSPT. D.O.A.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 194 DUKE of GLOUCESTER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle P. Last LEWNES

4. DATE OF DEATH: Month SEPT Day 25 Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: OCT 23 1894

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. RESTAURATEUR

10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT

11. BIRTHPLACE (State or foreign country): ARNA GREECE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PETER LEUNES

14. MOTHER'S MAIDEN NAME: FRANCES KARAMBELAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 216-32-7401

17. INFORMANT: FRANCIS J. LEUNES Address: BAY RIDGE W. LAKE DR. ANNAP. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ____
DUE TO (c): ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): E. Linhardt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: 9/28/66

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT 27, A66

23c. NAME OF CEMETERY OR CREMATORY: ST. MARY'S CEM.

23d. LOCATION (City, town or county) (State): ANNAPOLIS MARYLAND

24. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS ADDRESS: ANNAPOLIS MD

25a. REC'D BY REGISTRAR DATE: SEP 28 1966

25b. REGISTRAR'S SIGNATURE: [illegible]

VR AISME (5) 5M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12220

CERTIFICATE OF DEATH

12215

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- Severn
d. STREET ADDRESS: 2 Washington Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Naomi — Middle: Mae — Last: LOWMAN
4. DATE OF DEATH: Month: September — Day: 10, — Year: 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 31, 1914
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GEORGE GARDNER
14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: KENNETH F. LOWMAN — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491.X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Sept. 9, 1966, to Sept. 10, 19 66 that (I) (~~saw~~) last saw the deceased alive on Sept. 10, 1966, and that death occurred at 2:45 A.M, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/12/66
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 59 Franklin Street, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-13-1966
23c. NAME OF CEMETERY OR CREMATORY: MAYO MEMORIAL CEM.
23d. LOCATION (City or Town) (County) (State): MAYO A.A.Co MD.

24. FUNERAL DIRECTOR — ADDRESS: JOHN M. TAYLOR-SONS ANNAPOLIS MD
25a. REC'D BY REGISTRAR DATE: SEP 13 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12221 (M) 12216

1 PLACE OF DEATH
a. COUNTY: A. Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: A. Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Pasadena. (Solley Rd)
d. STREET ADDRESS: ~~[illegible]~~ RT # 9 BOX 180-A
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First OTTO Middle FRANCIS Last LUEDTKE

4. DATE OF DEATH: Month Sept. Day 29 Year 1966

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/3/1914

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Punch Press operator

10b. KIND OF BUSINESS OR INDUSTRY: Natl Plastic Co

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Otto Luedtke

14. MOTHER'S MAIDEN NAME: (unknown)

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No

(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 219-05-9544

17. INFORMANT: Wife (Mrs. Hilda Luedtke) Address: ~~[illegible]~~ Pasadena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): SHOCK
DUE TO (b): Acute myocardial infarction
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/28/, 1966, to 9/29/, 1966, that (I) (we) last saw the deceased alive on 9/29/ 1966, and that death occurred at 12:10 AM, from causes and on the date stated above.

22a SIGNATURE: Edmond I. Moushabek
ATTENDING PHYS. ☒ M.D. MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED:

22c PHYSICIAN'S NAME (Type): EDMOND I. MOUSHABEK

22d ADDRESS: 510 HARLEY STATION ROAD GLEN BURNIE, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 3, 1966

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md

24. FUNERAL DIRECTOR: Richard V. Singleton

ADDRESS: Glen Burnie

25a. RECD BY REGISTRAR DATE: OCT 3 1966

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12222 — 12217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: 34262
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rachel — Middle: — Last: Mackall

4. DATE OF DEATH: Month: September — Day: 30 — Year: 19 66

5. SEX: F.

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/10/1890

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Watts

14. MOTHER'S MAIDEN NAME: Elizabeth Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alene Little — Address: Rt. 5 Box 73 Annap. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema
DUE TO (b): Myocardial infarction
DUE TO (c): Arteriosclerotic Cardiovascular disease

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 421

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 9, 1966, to Sept. 30, 1966, that (I) (we) last saw the deceased alive on Aug. 9, 19 66, and that death occurred at 3:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ray M. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/30/66

22c. PHYSICIAN'S NAME (Type): Ray M. Smith, M. D.

22d. ADDRESS: Hahn Professional Bldg., Severna Pk., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-4-1966

23c. NAME OF CEMETERY OR CREMATORY: Tyron Neck

23d. LOCATION (City, town or county) (State): Severna Park, Md.

24. FUNERAL DIRECTOR — ADDRESS: William Ricketts Annap. Md.

25a. REC'D BY REGISTRAR: OCT 3 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12218

1 PLACE OF DEATH
a. COUNTY: A.Arco. — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - North Arundel Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena -
d. STREET ADDRESS: Rt 4 - Box 432.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Leonard — Middle: G. — Last: MARION

4. DATE OF DEATH: Month: 9 — Day: 21 — Year: 1966

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 5/25/15

9 AGE (In years last birthday): 51 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b KIND OF BUSINESS OR INDUSTRY: Construction

11 BIRTHPLACE (State or foreign country): Ohio

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Alex Marion

14. MOTHER'S MAIDEN NAME: Violet Rowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 278-05-1836

17. INFORMANT: Address: Mrs. Lillian Marion-Rt.4, Box 432, Pasadena, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b): Coronary Insufficiency
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

9. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.

EXAMINER'S NAME (Type): E. Linhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county):

22. DATE SIGNED: 9.21.66.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 9-24-1966

23c NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park

23d LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR: George J. Gonce — ADDRESS: 4001 Ritchie Hgwy., Baltimore

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12224 12213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Millersville, Md.
c. LENGTH OF STAY IN 1b: 13 days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE / b. COUNTY: 3703 N. 14th St., Arlington, Va.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington, Virginia

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Knollwood Manor Nursing Home
d. STREET ADDRESS: Millersville, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Ellen Last: Martin
4. DATE OF DEATH: Month: Sept. Day: 24 Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/15/81
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months 1 Days 9 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Mongul, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Gruver
14. MOTHER'S MAIDEN NAME: Martha Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unknown (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Getz Address: 2450 South 5th St Steelton, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour
DUE TO (b): Arteriosclerosis — many years
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous cerebral thrombosis, pneumonia, hypertension, heart failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 30 August, 1966, to 24 Sep, 1966, that (I) (we) last saw the deceased alive on 18 Sep 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 27 Sep 66
22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M. D.
22d. ADDRESS: South River Medical Bldg, Edgewater, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 9-29-66
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill
23d. LOCATION (City, town or county) (State): Shippensburg, Pa.

24. FUNERAL DIRECTOR: Harold M. Zimmerman ADDRESS: Shermans Dale, Pa.
25a. REC'D BY REGISTRAR DATE: SEP 30 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1 M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12225

CERTIFICATE OF DEATH

12221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: A. A Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park — c. LENGTH OF STAY IN 1b: 8 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old County Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: A. A. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
   d. STREET ADDRESS: Old County Rd — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First J. — Middle L. — Last McGEADY

4. DATE OF DEATH: Month 9 — Day 9 — Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 21 1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINCIPAL

10b. KIND OF BUSINESS OR INDUSTRY: Elem. School

11. BIRTHPLACE (County & State, or foreign country): Allegany Co, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McGEADY

14. MOTHER'S MAIDEN NAME: Julia CAVANAUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: EAMONN' Mc GEADY — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: acute

Part I Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular disease — 10 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1958, to Sept. 1966, that (I) (we) last saw the deceased alive on Sept. 9 1966, and that death occurred at 3A M. from the causes and on the date stated above.

22a. SIGNATURE: Francis I Codd M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept 11, 1966

22c. PHYSICIAN'S NAME (Type): Francis I. Codd M.D.

22d. ADDRESS: Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9-17-66 — 23c. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE — 23d. LOCATION (City, town or county) (State): DORSEY Md.

24. FUNERAL DIRECTOR: Robert S. Barranco — ADDRESS: Severna Pk

25a. REC'D BY REGISTRAR DATE: SEP 13 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

ROBERT S. BARRANCO - Md.

VR A15 (4) 2DM 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12226

CERTIFICATE OF DEATH

12221

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie N.W.
d. STREET ADDRESS: 100 Old Annapolis Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grover — Middle: Cleveland — Last: MORGAN

4. DATE OF DEATH: Month: September — Day: 21 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 22, 1884

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. PRINTER

10b. KIND OF BUSINESS OR INDUSTRY: PRINTING Co

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: late Charles Morgan

14. MOTHER'S MAIDEN NAME: late Mary M. Mozeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Anna Morgan — Address: Odenton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO
(b): Myocardial infarction
DUE TO
(c): Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~the physician~~) attended the deceased from July 11, 19 66, to Sept. 21, 19 66 that (I) (~~he~~) last saw the deceased alive on Sept. 21 19 66, and that death occurred at 11:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Robert O Biern M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: September 22, 66

22c. PHYSICIAN'S NAME (Type): Robert O. Biern M. D.

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/24/66

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem

23d. LOCATION (City or Town) (County) (State): Glen Burnie Md

24. FUNERAL DIRECTOR: Robert S. Barranco

ADDRESS: Severna Park, Md.

ROBERT S. BARRANCO

25a. REC'D BY REGISTRAR DATE: SEP 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12227 Item #9 Film #G381 10/1/66 ms 12222

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 428 Castle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: #33177 William — Middle: J. — Last: Myers

4. DATE OF DEATH: Month: 9 — Day: 8 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ sep

8. DATE OF BIRTH: 6/16/1903

9. AGE (If under 1 year or 1 day old, last birthday): 53/63 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sea Merchant

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Myers

14. MOTHER'S MAIDEN NAME: Harriet

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-03-6095

17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease
DUE TO
(c): Inanition, Chronic Alcoholism

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/1/ , 19 66 , to 9/8 , 19 66 , that (I) (we) last saw the deceased alive on 9/8/ 19 66 , and that death occurred at 2:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/66

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 9/14/66

23c. NAME OF CEMETERY OR CREMATORY: M.C.J. Md.

23d. LOCATION (City or Town) (County) (State): Balto. Md.

24. FUNERAL DIRECTOR: William Reese, II — Annap. Md.
ADDRESS

25a. REC'D BY REGISTRAR DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12223 **CERTIFICATE OF DEATH** 12223

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 30 Randall St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Elmer — Last: NELSON

4. DATE OF DEATH: Month: September — Day: 12 — Year: 19 66

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 8. DATE OF BIRTH: Sept. 7, 1912 — 9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSURANCE
10b. KIND OF BUSINESS OR INDUSTRY: Public Relations
11. BIRTHPLACE (County & State, or foreign country): ANNAPOLIS, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN A. NELSON
14. MOTHER'S MAIDEN NAME: ALICE STEWART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHN A. NELSON — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: immediate
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(did not)~~ attended the deceased from 10/29, 1965, to Sept. 12, 1966, that (I) ~~(did not)~~ last saw the deceased alive on Sept. 12, 19 66, and that death occurred at 4:15 PM M, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman — M.D — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 9/14/66
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-15-66
23c. NAME OF CEMETERY OR CREMATORY: CEDAR Bluff
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: John M. Taylor & Son — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: SEP 16 1966
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1 M.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G381 10/25/66 mh

12229

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12224

1. PLACE OF DEATH
   a. COUNTY: AA. CO — MARYLAND
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A- North Arundel

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: MD
   b. COUNTY: AA CO
   c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Severn — 021
   d. STREET ADDRESS: Dorsey-Station
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Willard J. — Last: ODENBECK

4. DATE OF DEATH: Month: Sept. — Day: 2, — Year: 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-9-99

9. AGE (In years last birthday): 67 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Julius Odenbeck

14. MOTHER'S MAIDEN NAME: Catherine Shumaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): 1923 - 1924

16. SOCIAL SECURITY NO: 215-09-0143

17. INFORMANT - Address: Mrs. Mary H. Odenbeck, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I DEATH WAS CAUSED BY
   IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO
   (b):
   DUE TO
   (c):
   4344
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

   PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 9.2.66.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6 Sept. 66

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial

23d. LOCATION (City or Town) (County) (State): Howard Co., Md.

24. FUNERAL DIRECTOR ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. RECEIVED BY REGISTRAR DATE: SEP 6 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

M 12230

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12225

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and [illegible] event within 72 hours after death.

1 PLACE OF DEATH — a COUNTY: ANNE ARUNDEL — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills

c LENGTH OF STAY IN 1b:

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Gambrills

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) — a STATE: Maryland — b COUNTY:

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills

d STREET ADDRESS:

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Sarah — Middle — Last Oliver

4 DATE OF DEATH: Month September — Day 6 — Year 1966

5 SEX: Female

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 8/11/1904

9 AGE (In years last birthday) 62 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): S. Carolina

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Alex Owens

14 MOTHER'S MAIDEN NAME: Carrie Owens

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO:

17 INFORMANT: Jack Byrd — Address: 1502-41st St. Wash. D.C.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Stabwound of chest

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:

(b):

DUE TO

(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Unknown

20c TIME OF INJURY Month, Day, Year: Hour a.m. Unknown p.m. — Unknown 9

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town) Gambrills (County) (State) Md.

21 **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: September 7, 1966

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 9-11-1966

23c. NAME OF CEMETERY OR CREMATORY: Wilson Memorial

23d LOCATION (City or Town) (County) (State): Gambrills Md

24 FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.

25a REC'D BY REGISTRAR DATE: SEP 13 1966

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12231 Item #9 Final #3361 1/6/67 DG 12226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel Co. MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md.
   c. LENGTH OF STAY IN lb. 4-27-61-70 9-28-66
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plaza Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A.A. Co
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 425 Myrtle Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Charlotte Middle: Lottie Last: Dorsey

4. **DATE OF DEATH**: Month: 9 Day: 28 Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 12-14-1871

9. AGE (In years last birthday): 94 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Harrod

14. MOTHER'S MAIDEN NAME: Eliza Cobb ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give wer or dates of servica): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Fraser, Plaza Manor, Inc.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Status Epileptic — INTERVAL BETWEEN ONSET AND DEATH: Several Years

4211

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardio Vascular Disease — Unknown

DUE TO (c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTR.BUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-27 1961 to 9-28 1966 that (I) (we) last saw the deceased alive on 9-28- 19.66., and that death occurred at 5P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/28/66

22c. PHYSICIAN'S NAME (Type): Richard H. Hunt

22d. ADDRESS: 100 Chiswell Lane, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-1-66

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Charles R. Law - 802 Madison Ave.

25a. REC'D BY REGISTRAR DATE SEP 30 1966

25b. REGISTRAR'S SIGNATURE: Charles Lange

VR A15 (4)
20M 5-63

Items 18&21 Film 381 9-29

1

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12227

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part I, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lithicum
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): near Lithicum (in wooded area)

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Lanthicum
d. STREET ADDRESS: 400 S. Hammonds Ferry Road,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
LILLIE	MAY	PFAFF	September	10	19 66

5 SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		May 28, 1895	71 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Retired		Maryland	U. S. A.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Richard Ridgway	Anna Albert

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service	16 SOCIAL SECURITY NO.	17 INFORMANT Address
No	213-05- 3066	MR. HYLANT L. PFAFF, 919 RAMBELING DRIVE #28

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart idsease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

22. DATE SIGNED: September 11, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	9-14-66	LOUDON PARK CEMETERY	BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21229	SEP 14 1966	[illegible] Judge

VR A15ME (5) 6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12233 — 12228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: A A
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A A
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5307 Fernpark Ave — Baltimore 7
   d. STREET ADDRESS: 5307 Fernpark Ave — Howard Park Baltimore 7
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPHINE Middle Last POOLE

4. DATE OF DEATH: Month 9 Day 2 Year 1966

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/29/01

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months ____ Days ____
   IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: James Poole — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (b): Hypertension
   DUE TO (c):
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/29/66 19__ to 9/2, 1966, that (I) (we) last saw the deceased alive on 9/1/66 19__, and that death occurred at 5 A M, from the causes and on the date stated above.

22a. SIGNATURE: J. B. Ramirez — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/2/66

22c. PHYSICIAN'S NAME (Type): J. B. RAMIREZ MD.

22d. ADDRESS: 3927 ANNAPOLIS RD Baltimore 21 / 1672 NORTH BOURNE RD Ballimore 13

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-6-66

23c. NAME OF CEMETERY OR CREMATORY: Arbutus Cem

23d. LOCATION (City, town or county) (State): Arbutus, Md

24. FUNERAL DIRECTOR: Ebony O. Wilson — ADDRESS: 1000 Bromley Ave.

25a. REC'D BY REGISTRAR DATE: SEP 7 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1 8

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12234

CERTIFICATE OF DEATH

12229

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. General Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: R.F.D. 2 By 296A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louis — Middle: — Last: Porter

4. DATE OF DEATH: Month: 9 — Day: 26 — Year: 1966

5. SEX: M

6. COLOR OR RACE: Col.

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10/15/96

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: Horace Porter

14. MOTHER'S MAIDEN NAME: Katie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes

16. SOCIAL SECURITY NO.: W.W.I 214-05-5066

17. INFORMANT: Edna Porter — Address: R.F.D. 2 By 296A Annapolis Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): auto Emphysema arrest — INTERVAL BETWEEN ONSET AND DEATH: 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardio Vascular
DUE TO (c): Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-20-66 19 to 9-26-66 19, that (I) (we) last saw the deceased alive on 9-25-66 19, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: A. T. Allen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A. T. Allen

22d. ADDRESS: 62 Cathedral St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/29/66

23c. NAME OF CEMETERY OR CREMATORY: Broad Neck

23d. LOCATION (City, town or county) (State): St. Margarets, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Lease, II

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 27 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 7-62

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12235 — 12230

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): BALTIMORE
d. STREET ADDRESS: 1672 NORTHBOURNE RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jorge — Middle: Hermenegildo — Last: Ramirez

4. DATE OF DEATH: Month: SEPT — Day: 4 — Year: 1966

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☑ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 4-13-03

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Meats

11. BIRTHPLACE (County & State or foreign country): SANTIAGO DE CUBA

12. CITIZEN OF WHAT COUNTRY?: CUBA

13. FATHER'S NAME: JORGE

14. MOTHER'S MAIDEN NAME: CARIDAD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: J. B. RAMIREZ MD — Address: Baltimore 12 Md 1672 NorthBourne Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): LYMPHOSARCOMA ; PYELONEPHRITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that ~~(I) (this hospital)~~ attended the deceased from AUG 29, 1966, to Sept 4, 1966, that (I) ~~(we)~~ last saw the deceased alive on Sept 4 1966, and that death occurred at 8:30 PM, from causes and on the date stated above.

22a. SIGNATURE: Joseph A. Mead Jr, MD — M.D. — ATTENDING PHYS ☑ — MED. DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: Sept 4, 1966

22c. PHYSICIAN'S NAME (Type): Joseph. A. MEAD, JR, M.D.

22d. ADDRESS: SEVERNA PARK, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-7-1966

23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: G. Howard Strong — ADDRESS: 3207 W. North Ave.

25a. RECD. BY REGISTRAR DATE: SEP 9 1966

25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12236

CERTIFICATE OF DEATH

12231

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
d. STREET ADDRESS: Franklin Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Paul	Dean	REMSEN	Sept	5	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Cauc		July 14, 06	60yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
US Gov't - Ret	Retired	Ind.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Melvin Remsen	Goodnight

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes Peacetime	226-44-8010	Mrs. Juanita H Remsen - Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Arteriosclerotic heart disease of coronary arteries — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1961, to Sept 5, 1966, that (I) (we) last saw the deceased alive on Aug 15, 1966, and that death occurred at 5:4 M, from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/5/66
22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sep 8, 66	Arlington Nat Cem	Arlington, Virginia

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Wm. Lee & Sons F. H. 3004th NE, Wash	DC SEP 8 1966	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12237

CERTIFICATE OF DEATH

12232

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
d. STREET ADDRESS: 8 Oakley[illegible] Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): #33198 — First: Hadley — Middle: — Last: Rose

4. DATE OF DEATH: Month: 9 — Day: 8 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/29/1905

9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathaniel Rose

14. MOTHER'S MAIDEN NAME: Margaret

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unk. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 228/01/5887 Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumoni[illegible]
DUE TO
(b): Arteriosclerosis
DUE TO
(c): Hypertensive
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443 X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardio Vascular Disease, Uremia, Chronic Brain Syndrome

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ---------- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/3/ , 19 66, to 9/8/ , 1966, that (I) (we) last saw the deceased alive on 9/8/ 1966, and that death occurred at 4:15 A.M, from causes and on the date stated above.

22a. SIGNATURE: L. Benedict

M.D ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/66

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 10, 66

23c. NAME OF CEMETERY OR CREMATORY: LAKEVIEW MEM'L PARK

23d. LOCATION (City or Town) (County) (State): BALTIMORE CO., MD.

24 FUNERAL DIRECTOR: R.V. SINGLETON

ADDRESS: GLEN BURNIE, MD.

25a. REC'D BY REGISTRAR DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12235 — 12233

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b: 43 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Telegraph Road

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: Box 299) Old Telegraph Rd. (Rt. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: T. C. — Last: ROSE

4. DATE OF DEATH: Month: September — Day: 27, — Year: 19 66

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White	NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	June 3, 1882	84 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman (Ret.)	Balto. Fire Dept.	Baltimore, Co. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Christopher Rose	Annie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
No	None	213-22-2213	Mr. J. Edward Rose (Son)	Old Telegraph Rd. Rt.1 Box303

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Cerebral Infarct — INTERVAL BETWEEN ONSET AND DEATH: Suddenly

DUE TO (b): Chronic Arteriosclerosis — 5 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Cardio Vas. Disease — 4 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS A TOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19	20d. INJURY OCCURRED: While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 15/66 to Sept 25, 1966 that (I) (we) last saw the deceased alive on Sept 26-1966 and that death occurred at 8 A.M. from causes and on the date stated above.

22a. SIGNATURE: Joseph Lukacs M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9/27-66

22c. PHYSICIAN'S NAME (Type): JOSEPH — LAST — ADDRESS: ODENTON, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 30/66	Nichols Bethel Cemetery	Odenton, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Richard V. Singleton	Glen Burnie, Md.	SEP 29 1966	Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12239

CERTIFICATE OF DEATH

12239

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lothian
d. STREET ADDRESS: Patuxent Mobile Estates
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ray — Middle: G. — Last: RUPP

4. DATE OF DEATH: Month: September — Day: 16 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 6, 1880

9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: MATCH INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: FREDERICK RUPP

14. MOTHER'S MAIDEN NAME: NETTIE PATTINGALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: 276-16-3675

17. INFORMANT: Louis R. Rupp — Address: 705 Plumb St. Vienna VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of the Colon — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1555

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~physician~~ attended the deceased from 9/13, 19 66, to Sept. 16, 1966, that (I) ~~saw~~ last saw the deceased alive on Sept. 16, 19 66, and that death occurred at 7:50 AM, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/16/66

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.

22d. ADDRESS: 59 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 18 SEPT. 1966

23c. NAME OF CEMETERY OR CREMATORY: COLUMBIA GARDENS

23d. LOCATION (City or Town) (County) (State): ARLINGTON VA

24. FUNERAL DIRECTOR: RINALDI FUNERAL HOME, INC. — ADDRESS: 7405 GEORGIA AVE., N.W. WASH. DC 20012

25a. RECD BY REGISTRAR DATE: SEP 19 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME 10
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12240

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12235

1 PLACE OF DEATH
a COUNTY A N Co MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis -
c LENGTH OF STAY In Hosp. D.O.A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - Anne Arundel Gen.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MD. b COUNTY Talbot
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe - Talbot Co.
d STREET ADDRESS Bx 181 A Rt 50
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Leland	L	Sann Jr.	9	20	19 66

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
M	W.		7-31-47.	19 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
CHAUFFEUR	LAUNDRY	MD	USA

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
LELAND L. SANN SR.	LILLIAN OSTRANDER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT Address
NO	218-44-3729	Bonnie SANN - ABOVE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound - Skull — INTERVAL BETWEEN ONSET AND DEATH: Instan
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
	Gun shot wound - accidentally discharged.			
20c TIME OF INJURY Month, Day, Year Hour a.m. (p.m.)	20d INJURY OCCURRED While at work ☐ Not While at work ☒	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)
9/20 1966		Home		Talbot MD

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.
EXAMINER'S NAME (Type) E. Lin Hancock
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED 9-20-66

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/24/66	Glen Haven	Glen Burnie A.A. Md

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Robert A Bernard Severna Pk, Md	SEP 26 1966	Charles Judge

ROBERT S. BARRAGE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12241

CERTIFICATE OF DEATH

13636

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G. Meade
c. LENGTH OF STAY IN 1b: Civ Emerg
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HOWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JESSUP
d. STREET ADDRESS: ROUTE #2, BOX 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: FREDERICK — Last: SCHMELTZ

4. DATE OF DEATH: Month: SEPTEMBER — Day: 30 — Year: 19 66

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 19 JUL 1889

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (County & State, or foreign country): Howard County, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Schmeltz

14. MOTHER'S MAIDEN NAME: Elizabeth Eichmann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-128-062

17. INFORMANT — Address: Mrs. Iva Lee Schmeltz, Jessup, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Probably, acute myocardial infraction	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Chronic Obstrictive Emphysema	15 Min
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that [illegible] saw the deceased [illegible] WAS DOA [illegible] on 30 Sept 19 66, and that death occurred at 9:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert F. Cullen Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 30 Sept 66

22c. PHYSICIAN'S NAME (Type): ROBERT F. CULLEN, JR. CPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 10-4-66 — 23c. NAME OF CEMETERY OR CREMATORY: St Johns Lutheran — 23d. LOCATION (City, town or county) (State): Pleasant Corner Md

24. FUNERAL DIRECTOR — ADDRESS: [illegible] Sandy Md.

25a. REC'D BY REGISTRAR DATE: OCT 10 1966 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12242 — 12236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Posadena
d. STREET ADDRESS: Rt 164 Long Point Posadena
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle F — Last SELDNER
4. DATE OF DEATH: Month 9 — Day 4 — Year 1966
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/12/12
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Helper
10b. KIND OF BUSINESS OR INDUSTRY: Brewery
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Abram Seldner
14. MOTHER'S MAIDEN NAME: Edna Rose Dunn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.: 217-22-0062
17. INFORMANT — Address: Mrs. Genevieve A. Hemp (Aunt) Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b): Arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension — Pneumonia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/23, 19 66, to 9/4/66 19, that (I) (we) last saw the deceased alive on 9/3/66 19, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: J. B. Ramirez — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/4/66
22c. PHYSICIAN'S NAME (Type): J. B. RAMIREZ
22d. ADDRESS: 3967 ANNAPOLIS RD Balt mm 27 / 1672 NORTHBOURNE RD Baltimore 12

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
23b. DATE THEREOF: Sept 8/66
23c. NAME OF CEMETERY, OR CREMATORY: Lorraine Park Mausoleum
23d. LOCATION (City, town or county) (State): Balto, Md.
24. FUNERAL DIRECTOR: V. L. Singleton — ADDRESS: Singleton Funeral Home Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: SEP 7 1966
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12243

CERTIFICATE OF DEATH

12237

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairhaven
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Iva — Middle: Marie — Last: SHERBERT

4. DATE OF DEATH: Month: September — Day: 23 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 13, 1903

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Walton

14. MOTHER'S MAIDEN NAME: Maggie Marquess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 216-46-8799

17. INFORMANT — Address: Walter W. Sherbert, Fair Haven, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA (2) — INTERVAL BETWEEN ONSET AND DEATH: 1 Day + 3 Days
DUE TO (b): Myocardial
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXXX~~) attended the deceased from 9-12, 1966, to Sept. 23, 1966, that (I) (~~XXX~~ last saw the deceased alive on Sept. 23 1966, and that death occurred at 9:00 AM M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 9.23-66

22c. PHYSICIAN'S NAME (Type): F M SHIPLEY

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 26, 1966
23c. NAME OF CEMETERY OR CREMATORY: Friendship Chr. Cemetery
23d. LOCATION (City or Town) (County) (State): Friendship A. A. Co. Md.

24. FUNERAL DIRECTOR — ADDRESS: Hutchins Funeral Home Owings Md.

25a. RECD BY REGISTRAR — DATE: SEP 26 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12244

CERTIFICATE OF DEATH

12238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The remainder remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva
d. STREET ADDRESS: Sylvan Shores
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lisa — Middle: Marie — Last: Shields

4. DATE OF DEATH: Month: September — Day: 3 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 31, 1966

9. AGE (In years last birthday) yrs.:

IF UNDER 1 YEAR: Months: — Days: 2
IF UNDER 24 HRS.: Hours: 6 — Min.: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Roy James Shields

14. MOTHER'S MAIDEN NAME: Linda Anne Irby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1/16 X

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~the hospital~~) attended the deceased from Aug. 31, 1966, to Sept. 2, 1966, that (I) (~~xx~~) last saw the ~~deceased~~ alive on Sept. 2, 1966, and that death occurred at 1:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Willard F Smith — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/6/66

22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9-6-66

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest

23d. LOCATION (City or Town) (County) (State): Annapolis MD.

24. FUNERAL DIRECTOR: John M. Taylor & Son — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: SEP 8 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12245 — 12239

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 35 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Louis — Middle: Luvean — Last: SIEGERT Jr.
4. DATE OF DEATH: Month: September — Day: 23 — Year: 19 66

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 27, 1895
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (County & State, or foreign country): Galesville Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Louis L. Siegert Sr.
14. MOTHER'S MAIDEN NAME: Ella Mae Nutwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes give war or dates of service) WW I
16. SOCIAL SECURITY NO.
17. INFORMANT: Sophie Siegert — Address: Galesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema
DUE TO (b): Coronary artery disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 6 hrs. hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the doctor~~) attended the deceased from 11-10-, 1965, to Sept. 23, 1966 that (I) (~~he~~) last saw the deceased alive on Sept. 23 1966, and that death occurred at 5:10 AM M, from causes and on the date stated above.

22a. SIGNATURE: J.M. Shipley — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-23-66
22c. PHYSICIAN'S NAME (Type): F.M. SHIPLEY
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-25-66
23c. NAME OF CEMETERY OR CREMATORY: Galesville Mausoleums
23d. LOCATION (City or Town) (County) (State): Galesville, Md

24. FUNERAL DIRECTOR: T.A. Hardesty — ADDRESS: Galesville, Md

25a. REC'D BY REGISTRAR DATE: SEP 28 1966
25b. REGISTRAR'S SIGNATURE: C. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12246 Item 9 Per telephone call to Crownsville Hosp. 10/13/66 mh 12240

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 yrs. 6 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 55 Sharpe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): #26979 — First: Thomas — Middle — Last: Simms

4. DATE OF DEATH: Month: 9 — Day: 27 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/22/1888

9. AGE (In years last birthday): 75 78 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Simms

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Inanition
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150 X
DUE TO (c): Ca of the esophagus with metastasis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): -------

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. ------- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/10/ , 1964 , to 9/27/ , 1966, that (I) (we) last saw the deceased alive on 9/27/ 1966 , and that death occurred at 1:30 A. M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9/27/66

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-1-1966

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill C

23d. LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR — ADDRESS: William Fiore, Jr. Annapolis Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12247

CERTIFICATE OF DEATH

12241

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN
c. LENGTH OF STAY IN 1b: LIFE

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERN
d. STREET ADDRESS: Box 226 Rte #2 Queenstown Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 226 Rte 2 Queenstown Rd

3. NAME OF DECEASED (Type or print): First: William — Middle: E. — Last: Snowden

4. DATE OF DEATH: Month: Sept — Day: 19 — Year: 1966

5. SEX: M

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOV. 23-1879

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer & Chauffeur.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): A. A. Co. MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Snowden

14. MOTHER'S MAIDEN NAME: Mary Jane Snowden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
If yes, give war or dates of service:

16. SOCIAL SECURITY NO: 218-12-7460A

17. INFORMANT: Beatrice Matthews — Address: Severn Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio - Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 6-12 mos.
DUE TO
(b): Arteriosclerosis — 4-6 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour: o. m. / p. m.; 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 9/15 19 66, to 9/19 19 66, that (I) (we) last saw the deceased alive on 9/19 1966, and that death occurred at .M. from the causes and on the date stated above.

22a SIGNATURE: Chas. L. Ball Jr. M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 9/19/66

22c PHYSICIAN'S NAME (Type)

22d ADDRESS: Linthicum Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 9/23/66
23c NAME OF CEMETERY OR CREMATORY: ARBUTUS MEM. PK
23d LOCATION (City, town, or county) (State): ARBUTUS - BALTO MD 21227

24. FUNERAL DIRECTOR'S SIGNATURE: Markham & Hays
ADDRESS: 638 N Gilmor St

25a REC'D BY REGISTRAR DATE: SEP 22 1966
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12245 12242

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: ANNE ARUNDEL — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: MD b. COUNTY: ANNE ARUNDEL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE — c. LENGTH OF STAY IN 1b: 11111	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. - North Arundel	d. STREET ADDRESS: 1327 Meadow View Rd. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print): First: Douglas — Middle: L. — Last: Snyder	4 DATE OF DEATH: Month: 9 — Day: 13 — Year: 1966
5 SEX: M	6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: Jan 27, 1935
9 AGE (In years last birthday): 31 yrs	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor	10b. KIND OF BUSINESS OR INDUSTRY: United Airlines
11 BIRTHPLACE (State or Foreign country): Watertown S. Dakota	12 CITIZEN OF WHAT COUNTRY?: U.S.A.
13 FATHER'S NAME: Earl Snyder	14. MOTHER'S MAIDEN NAME: Daisey Eblen
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): Korean	16 SOCIAL SECURITY NO: Unknown
17 INFORMANT: Richard E. Snyder (Brother) — Address: 642 Haddon Ave Collingswood N.J.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY — IMMEDIATE CAUSE (a): Gun Shot wound Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 176 X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Self inflicted gun shot wound

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 9/13 1966

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Woods

20f (City or town): Glen (County): Anne Arundel (State): MD

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): F. Linhardt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)

22. DATE SIGNED: 9/13/66

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Sept. 16, 1966	Arlington National Cem.	Fort Meyer, Virginia

24 FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Richard V. Singleton	Glen Burnie, Md.	SEP 15 1966	J. Charles Judge

VR A15ME (5)
6M 7/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12249

CERTIFICATE OF DEATH

12243

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 406 Ferndale Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: Katherine — Last: SOUTH
4. DATE OF DEATH: Month: September — Day: 7 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 1, 1881
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ERNEST LETTAU
14. MOTHER'S MAIDEN NAME: MARY MANGOLD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: MRS. DORIS L.JAKUBUWSKI, 406 FERNDALE AVENUE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ASPIRATED FEEDING (SUSPECTED)
DUE TO
(c): EPIGLOTTAL INCOMPETENCE

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC CHRONIC BRAIN SYNDROME
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this physician) attended the deceased from ____, 19____, to Sept. 7, 1966, that (I) (We) last saw the deceased alive on Sept. 7 1966, and that death occurred at 10:40 AM, from causes and on the date stated above.

22a. SIGNATURE: Charles M Kinsinger M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7 Sep 1966
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-10-66
23c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK CEMETERY
23d. LOCATION (City or Town) (County) (State): BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229
25a. REC'D BY REGISTRAR DATE: SEP 13 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12250

CERTIFICATE OF DEATH

12244

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Franklin Manor

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
d. STREET ADDRESS: Franklin Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: B. — Last: Stabler
4. DATE OF DEATH: Month: Sept. — Day: 30 — Year: 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 29, 1915
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months: 8 — Days: 1
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman
10b. KIND OF BUSINESS OR INDUSTRY: C.&P.Tel.Co.
11. BIRTHPLACE (County & State, or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Harold B. Stabler
14. MOTHER'S MAIDEN NAME: Sarah Farquhar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 578-07-8756
17. INFORMANT: Wife — Juliet N.Stabler — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: One hour

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan ____, 19 63, to Sept 30, 19 66, that (I) (we) last saw the deceased alive on Sept 30 19 66, and that death occurred at 4:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Willard F Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 9/30/66
22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-2-66
23c. NAME OF CEMETERY OR CREMATORY: Friends M.House Cem.
23d. LOCATION (City or Town) (County) (State): Sandy Spring, Maryland

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Maryland
25a. RECD BY REGISTRAR DATE OCT 7 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A III (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12251 12245

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-Annapolis (Crownsville,)
d. STREET ADDRESS: Box 580A, Rt. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Erford — Middle Clifton — Last STRINGER Sr.
4. DATE OF DEATH: Month September — Day 24 — Year 19 66

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: September 6, 1887
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): cook -ret.
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Erford Harrison Stringer
14. MOTHER'S MAIDEN NAME: Ellen Clifton Harlow

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO: 014-16-2450
17. INFORMANT: Erford C. Stringer-son — Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b): Coronary Artery Spasm
DUE TO (c): Arthritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-21-66, 19___, to 9-24-66, 19___, that (I) (we) last saw the deceased alive on 9-22-66 19___, and that death occurred at 7:15 A.M. 9-24-66, from causes and on the date stated above.

22a. SIGNATURE: Chas T. Allen M.D — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 9-24-66
22c. PHYSICIAN'S NAME (Type): Chas T. Allen
22d. ADDRESS: 62 Cathedral St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 28, 1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery Ft. Meyer
23d. LOCATION (City or Town) (County) (State): VA.

24. FUNERAL DIRECTOR: Beverley E. Hopping, Hopping Funeral Home
ADDRESS: Beverley E. Hopping, Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: SEP 27 1966
25b. REGISTRAR'S SIGNATURE: Warren Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12246

1 PLACE OF DEATH
a. COUNTY: A.A.CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): D.O.A - North. - Arundel - 99

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: AACO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 - 5th. Ave. - Glen Burnie
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Charles	M	Swain	9	27	1966

5 SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
M	W		8-26-18	48 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Manager	Meat Store	New Jersey	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joshua F. Swain	Ethel Bradley

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT Address
Yes WW 11		Mrs Norma Swain, 610 B. & A. Blvd. NE Glen Burnie, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per Line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carbon Monoxide
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7131
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
	Hose from exhaust into Car.				
20c TIME OF INJURY Hour a.m. p.m. / Month, Day, Year	20d INJURY OCCURRED While at work ☐ Not While at work ☒	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
9.27 1966		Highway		AACo.	MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): E. Linhardt. M.D
E. Linhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 9.27-66.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	29 Sept. 66	Glen Haven Memorial	Glen Burnie, Md.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Kirkley Funeral Home, Glen Burnie, Md.	SEP 29 1966	Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12253 — Reg. Dist.-No. 12247

1) PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Davidsonville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Md
b. COUNTY: AA.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Davidsonville
d. STREET ADDRESS: Davidsonville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fannie — Middle: Oregon — Last: Tucker

4. DATE OF DEATH: Month: 9 — Day: 18 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-23-1883

9. AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Sudley M.D.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Edwin Nutwell

14. MOTHER'S MAIDEN NAME: Mary Jane Minnick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: E. Marcelena Tucker — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular disease — years
DUE TO
(c) Arteriosclerotic cardiovascular disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/18 19 66 to 9/18 19 66 that I last saw the deceased alive on 9/18/66 19 , and that death occurred at 12 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED: 9/19/66

ACTUAL SIGNATURE: Charles H. Wirth M.D.

PHYSICIAN'S NAME (Type): Charles H. Wirth

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-20-66

22c. NAME OF CEMETERY OR CREMATORY: All Hallows

22d. LOCATION (City, town, or county): Davidsonville (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons

ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: SEP 22 1966

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12254 12248

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: — Last: TURNER

4. DATE OF DEATH: Month: September — Day: 22 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 10, 1904

9. AGE (In years last birthday): 61 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Richard Scott

14. MOTHER'S MAIDEN NAME: Jeanette Galloway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Cliff Turner — Address: Shadyside Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO (b): Hypertensive cardiovascular disease — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1961, 19___, to Sept. 22, 1966, that (I) (we) last saw the deceased alive on Sept 21 19 66, and that death occurred at 12:42 A.M. from causes and on the date stated above.

22a. SIGNATURE: Willard Smith — M.D — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/22/66

22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9.25.66

23c. NAME OF CEMETERY OR CREMATORY: St. Matthews

23d. LOCATION (City or Town) (County) (State): Shadyside Md.

24. FUNERAL DIRECTOR: William Rose # — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR — DATE SEP . . 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1 M

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12255 Item #9 Film #3380 9.15/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12249

1 PLACE OF DEATH
a. COUNTY A.A.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.H. – Chesapeake Beach.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE MD b. COUNTY A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis md (2-1)
d. STREET ADDRESS Owen Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Grace Middle: Lost: Turner
4. DATE OF DEATH Month: 9 Day: 8 Year: 1966
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-15-1899
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John T. Gross
14. MOTHER'S MAIDEN NAME: Julia A. Duke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Winfield Turner Address: R.3. Edgewood Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac. — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4.444
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Bad explosion – Back Creek.
20c. TIME OF INJURY Month, Day, Year: 2nd Hour o m (p m) 9/8 1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E. Linhardt M.D.
EXAMINER'S NAME (Type) E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)

22. DATE SIGNED 9/8/66.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9.13-1966
23c. NAME OF CEMETERY OR CREMATORY John Wesley
23d. LOCATION (City or Town) (County) (State) Annapeek Md.
24. FUNERAL DIRECTOR ADDRESS: William Reese Annapolis Md.
25a. REC'D BY REGISTRAR DATE SEP 13 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1225S 12250

IO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md.
c. LENGTH OF STAY IN 1b: 9-30-64 to Now
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 901 N. Bentalou Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur Middle: — Last: Tyson

4. DATE OF DEATH: Month: 9 Day: 28 Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 3-7-1900

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): unknown

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Mrs. Frazier Address: Plaza Manor, Inc.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Several Hours
DUE TO (b): CA. of prostate with metastases — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-30-64, 1964 to 9-28, 1966, that (I) (we) last saw the deceased alive on 9-28, 19 66, and that death occurred at 2:00 M, from the causes and on the date stated above

22a. SIGNATURE: Richard H. Hunt M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/28/66
22c. PHYSICIAN'S NAME (Type): Richard H. Hunt
22d. ADDRESS: 100 Cherry Lane, Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial **23b.** DATE THEREOF: 10-1-66
23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Wade H. Law ADDRESS: 802 Madison Ave., Balto., Md.

25a. REC'D BY REGISTRAR DATE: SEP 30 1966 **25b.** REGISTRAR'S SIGNATURE: Charles J. Lyle

VR A1S (4)
20M S 63

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12257 12251

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G MEADE, MD
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL FGGM

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE, MD
d. STREET ADDRESS: 1830-B Forrest Ave Ft Geo G. Meade, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNA Middle: UNDERWOOD Last:

4. DATE OF DEATH: Month: SEPT Day: 1 Year: 1966

5. SEX: F

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 17 Aug 39

9. AGE (In years last birthday): 27 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): BUDAORS, HUNGARY

12. CITIZEN OF WHAT COUNTRY?: GERMAN

13. FATHER'S NAME: JOSEF GEISELHARDT

14. MOTHER'S MAIDEN NAME: MARIA geb FRITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MRS. KATHRYN HELDT Box 117 Orion, Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Smoke Inhalation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Smoke Inhalation

20c. TIME OF INJURY Hour a.m. Month, Day, Year: 3:20 XX. 1 Sept 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): H ME

20f. (City or town) (County) (State): FT GEO G MEADE, MD

21. I certify that (I) ~~[illegible]~~ was DOA....., XX....., XX 1 Sept....., 1966 that (I) (XX) last ~~[illegible]~~ death occurred at 3:20 M, from the causes and on the date stated above.

22a. SIGNATURE: Henry M. Snell M.D.

22b. DATE SIGNED: 1 Sept 66

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): HENRY M. SNELL, CAPT, MC

22d. ADDRESS: KIMBROUGH ARMY HOSPITAL, FGGM

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6 sept. 1966

23c. NAME OF CEMETERY OR CREMATORY: SWEDONA LUTHERN CEMETERY

23d. LOCATION (City, town or county) (State): ORION, Illinois

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 7 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12258 — 12252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G. MEADE, MD
c. LENGTH OF STAY IN lb: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL, FGGM

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE, MD
d. STREET ADDRESS: 1830-B Forrest Ave Ft Geo G. Meade, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First KENNETH — Middle A. — Last UNDERWOOD

4. **DATE OF DEATH**: Month SEPT — Day 1 — Year 19 66

5. SEX: M

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 24 Dec 41

9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): Moline Rock Island, Ill

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DECEASED

14. MOTHER'S MAIDEN NAME: KATHRYN HELDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service): YES Mar 63-1 Sept 66

16. SOCIAL SECURITY NO.: 360-36-1588

17. INFORMANT — Address: MRS KATHRYN HELDT Box 117 Orion, Ill

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Smoke Inhalation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Smoke Inhalation

20c. TIME OF INJURY — Hour e.m.: 3:20 — Month, Day, Year: 1 Sept 19 66

20d. INJURY OCCURRED: White at work ☐ Not White at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) (County) (State): FT GEO G MEADE, MD

21. **I certify** that (I) ~~[illegible]~~ was DOA, ~~[illegible]~~ 1 Sept, 19 66, that (I) ~~(was)~~ last ~~saw the deceased alive on [illegible] 19~~, and that death occurred at 3:20 AM from the causes and on the date stated above.

22a. SIGNATURE: Henry M. Snell — M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1 SEPT 66

22c. PHYSICIAN'S NAME (Type): HENRY M SNELL, Capt, MC

22d. ADDRESS: KIMBROUGH ARMY HOSPITAL, FGGM

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6 Sept. 1966

23c. NAME OF CEMETERY OR CREMATORY: SWEDONA LUTHERN CEMETERY

23d. LOCATION (City, town or county) (State): ORION, Illinois

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Harold S. Wade, 550 Wash., Blvd, Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 7 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12259 Item #2c & d Rejm -6350 9/19/66 BC 12253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: ANNE ARUNDAL — MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS — c. LENGTH OF STAY IN 1b — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNAPOLIS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: A.A. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS // Glen Burnie — d. STREET ADDRESS: 7481 Furnace Br. Rd. VAN BUREN & HBAY RIDGE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MABEL — Middle: — Last: UPRIGHT

4. DATE OF DEATH: Month: 9 — Day: 7 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 10-25-1880

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): SAN FRANCISCO, CALF

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: SAMUEL GRUMAN

14. MOTHER'S MAIDEN NAME: BERTHA ASAK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 282-07-2943

17. INFORMANT: VAN BUREN — Address: BAY RIDGE. ANNAPOLIS NURSING HOME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 20 YRS

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. — DUE TO (b): — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 24 JUNE, 1966, to 7 SEPT, 1966, that (I) (we) last saw the deceased alive on 7 SEPT 1966, and that death occurred at 10P M, from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-7-66

22c. PHYSICIAN'S NAME (Type): EDUARD S. BECK — 22d. ADDRESS: FRANKLIN ST ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION — 23b. DATE THEREOF: 9-9-66 — 23c. NAME OF CEMETERY OR CREMATORY: FT LINCOLN — 23d. LOCATION (City, town or county) (State): BLADENSBURG MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: SEP 13 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12260

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12254

1 PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach,
c. LENGTH OF STAY IN 1a:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 209 Dale Road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b COUNTY: A Co
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach.
d STREET ADDRESS: 209 Dale Road.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
George	M.	VanFleet	9	22	19 66

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
M	W		10-22-21	44 yrs.				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Fuller Body		Md.	USA.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles E. Van Fleet	Ella Blanchard.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT Address
yes	WWII		Mrs Ann E. Van Fleet.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carbon Monoxide — DUE TO
9718
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Room closed — gasoline motor running at home

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
		Home	A Co		MD

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.
EXAMINER'S NAME (Type): E. Linhart Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 9-22-66

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town)	(County)	(State)
Buried.	9-26-66	Lorraine Park Cem	Baltimore		Md.

24 FUNERAL DIRECTOR ADDRESS: McCully. 237 Putapaco ave. Balto 25, Md.

25a REC'D BY REGISTRAR DATE SEP 27 1966

25b. REGISTRAR'S SIGNATURE

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1226 1225

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Severna Park
c. LENGTH OF STAY IN 1b 4 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt 1 - Jones - Severna Park,

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MD b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rt 1 - Box 408
d. STREET ADDRESS Severna Park Rd e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lottie Middle White Last Webster
4. DATE OF DEATH Month 9 Day 23-66 Year 19

5. SEX F
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH May 25, 1880
9. AGE (In years last birthday) 86 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Arthur White
14. MOTHER'S MAIDEN NAME Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 025-26-7930
17. INFORMANT Address Theodore W. White Rt 1 - Severna Park, md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Ca Bladder
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1964, 19__ to 1966, 19__, that (I) (we) last saw the deceased alive on 9-22-66 19__, and that death occurred at 9 PM, from the causes and on the date stated above.

22a. SIGNATURE Robert Rehn M.D. ATTENDING PHYS. ☒ MED. EXAMINER ☐ STAFF PHYS. ☐ 22b. DATE SIGNED M.D.
22c. PHYSICIAN'S NAME (Type) R. HAHN
22d. ADDRESS P.O. BOX 73 SEVERNA PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9-26-66
23c. NAME OF CEMETERY OR CREMATORY Carpenters Hill
23d. LOCATION (City, town or county) (State) Severna Pk - Rt 1 - Anne Arundel Co Md

24. FUNERAL DIRECTOR ADDRESS C. E. Hicks, 44 Annapolis, Md
25a. REC'D BY REGISTRAR DATE SEP 27 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12262 — 13662

1. PLACE OF DEATH
a. COUNTY: ~~Prince George~~ Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel - Rural
c. LENGTH OF STAY IN 1b: 45 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brock Bridge Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Laurel
d. STREET ADDRESS: Brock Bridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: FRANCES — Last: whitehead

4. DATE OF DEATH: Month: September — Day: 23 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 15 1883

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Roberson

14. MOTHER'S MAIDEN NAME: Mary Gantin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Margaret Whitehead, Laurel Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Carcinoma Stomach — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive C-V-A c Rt. Hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/1 19 66 to 9/22 19 66 that (I) (we) last saw the deceased alive on 6/22 19 66 and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: J M Warren M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J M WARREN — 22d. ADDRESS: Laurel Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 9-26-66 — 23c. NAME OF CEMETERY OR CREMATORY: St Marys Cem — 23d. LOCATION (City, town or county) (State): Laurel Md

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: De Witt Donaldson, Laurel, Md.

25a REC'D BY REGISTRAR DATE: OCT 10 1966 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12263 Items #2c & d Filed #3341 10/6/66 pc

CERTIFICATE OF DEATH

12256

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 67 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 122 Wilson Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ALICE — Middle: — Last: WIEGAND

4. DATE OF DEATH: Month: 9 — Day: 28 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6 June 1885

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Severn, AA Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathaniel Day

14. MOTHER'S MAIDEN NAME: Emma Dyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Victor A. Sulin, Severn, Md. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA
DUE TO (b): Hypertensive heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

INTERVAL BETWEEN ONSET AND DEATH: 6 days / years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/23, 1966 to 9/28, 1966 that (I) (we) last saw the deceased alive on 9/23 1966, and that death occurred at 5:45 PM, from causes and on the date stated above

22a. SIGNATURE: Ernest A Leipold M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 9-28-66

22c. PHYSICIAN'S NAME (Type): Ernest A. Leipold, M.D.

22d. ADDRESS: 425 Ritchie Hghy.SE, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1 Oct.66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore 25, Md.

24. FUNERAL DIRECTOR — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR — DATE: OCT 3 1966

25b. REGISTRAR'S SIGNATURE: J. Stanley Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12264 — 12257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis c LENGTH OF STAY IN 1b: Life	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md. 1618 Forest Drive
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital	d. STREET ADDRESS e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Mae	Middle: Belle	Last: WILLIAMS	4 DATE OF DEATH	Month: September	Day: 11	Year: 19 66
5 SEX: Female	6. COLOR OR RACE: White	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: May 10, 1914	9. AGE (In years last birthday): 52 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY: HOME	11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland	12 CITIZEN OF WHAT COUNTRY?: U.S.				
13 FATHER'S NAME: HENRY HENKENSEIFKEN	14. MOTHER'S MAIDEN NAME: SARAH						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —	16. SOCIAL SECURITY NO.	17. INFORMANT: WILLIAM J. WILLIAMS	Address: #2				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Metastatic Ca -
DUE TO (b): Ca of the ovary Unlisted
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1750
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(hospital)~~ attended the deceased from ____, 19____, to Sept. 11, 1966, that (I) ~~(we)~~ last saw the deceased alive on Sept. 11 1966, and that death occurred at 1:40 AM, from causes and on the date stated above.

22a. SIGNATURE: William F Krone M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-12-66

22c. PHYSICIAN'S NAME (Type): William F. Krone, M.D.

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: 9-13-1966	23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF CEM	23d. LOCATION (City or Town): ANNAPOLIS	(County): (State): MD.
24. FUNERAL DIRECTOR: JOHN M. TAYLOR SONS	ADDRESS: ANNAPOLIS MD	25a. RECD BY REGISTRAR DATE: SEP 13 1966	25b. REGISTRAR'S SIGNATURE: J Charles Jones	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12265

CERTIFICATE OF DEATH

12258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
d. STREET ADDRESS: Gibson Island, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OTIS Middle Harold Last WILLIAMSON

4. DATE OF DEATH: Month 9 Day 12 Year 1966

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-3-1893

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business man

10b. KIND OF BUSINESS OR INDUSTRY: Veneer (Self Emp)

11. BIRTHPLACE (County & State, or foreign country): Indianapolis, Ind.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Otis Elmer Williamson

14. MOTHER'S MAIDEN NAME: Ada Cole Williamson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): World War I

16. SOCIAL SECURITY NO.: 216-28-7662

17. INFORMANT: Richard B. Williamson — Address: Cockeysville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO
(b): Coronary Artery Disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to Sept. 12, 1966 that (I) (we) last saw the deceased alive on August 27 1966, and that death occurred at 7.31 P M, from causes and on the date stated above.

22a. SIGNATURE: Newland E. Day M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-13-66

22c. PHYSICIAN'S NAME (Type): Newland E. Day M.D.

22d. ADDRESS: 4- E. 33rd St. - Balto. Md. 21218

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 15/66

23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.

23d. LOCATION (City or Town) (County) (State): Pikesville, Md.

24. FUNERAL DIRECTOR: R. K. Singleton — ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: SEP 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12266 — 12259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1766

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie — c. LENGTH OF STAY IN 1b: —
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
   d. STREET ADDRESS: Box 174 Elvaton Rd. RT#1 — e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES — Middle F — Last WOOD

4. DATE OF DEATH: Month Sept — Day 26 — Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 24/1926

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (County & State, or foreign country): Elvaton, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H Wood

14. MOTHER'S MAIDEN NAME: Emma A STammer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 216-36-5441

17. INFORMANT: MRS Elsie E Wood (Wife) — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 7, 1966 to Sept 26, 1966, that (I) (we) last saw the deceased alive on Sept 26 1966, and that death occurred at 8:50 P.M. from causes and on the date stated above.

22a. SIGNATURE: M C Frank MD — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/26/66

22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD

22d. ADDRESS: 425 SC Ritchie Hwy Glen Burnie MD 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 29/66

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md

24. FUNERAL DIRECTOR — ADDRESS: Richard V Singleton Glen Burnie Md

25a. REC'D BY REGISTRAR DATE: SEP 28 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge